ACUMEN

MACRA Cost Measures:
2023 Comprehensive Reevaluation
Public Comment Summary Report

November 2023

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1 OVERVIEW

1.1 Project Title

Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) Episode-Based Cost Measures: Comprehensive Reevaluation

1.2 Dates

The Call for Public Comment ran from June 27, 2023, to July 21, 2023.

1.3 Project Overview

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC, to develop and maintain episode-based cost measures for the Merit-based Incentive Payment System (MIPS). The contract name is "Physician Cost Measures and Patient Relationship Codes (PCMP)." The contract number is 75FCMC18D0015, Task Order 75FCMC19F0004.

As part of the measure maintenance process, Acumen requested public comments on cost measures first implemented in MIPS in 2020. Acumen sought input from the public on the technical specifications of the twelve measures listed below to identify potential updates for the measures to remain up-to-date in assessing clinician cost performance. The Call for Public Comment included a set of questions about the measures as a starting point, but interested parties were encouraged to provide any feedback about the measure specifications.[1]

The measure maintenance process allows developers to ensure measures continue to function as intended and to consider refinements to the measure. On an annual basis, we review the MIPS measures that have been adopted and make minor updates to the cost measures to keep them up-to-date (e.g., coding updates). Every three years, measures are considered for comprehensive reevaluation. During comprehensive reevaluation, measure developers can more holistically review the measure, seek public comment, and consider many aspects of the measure specifications, not just the updates done through routine annual maintenance. In some instances, a measure might only need minor or no change to specifications, while other measures may undergo more substantive changes to improve the measure's importance, scientific acceptability, or usability.

Twelve measures were added to the MIPS cost performance category in performance year 2020, including ten episode-based cost measures (EBCMs) and two population-based cost measures. These twelve measures have been in MIPS for three years and are being considered for comprehensive reevaluation. The measures are listed in Table 1.

[1] MACRA Cost Measures: Call for Public Comment for Measure Reevaluation (2023), https://mmshub.cms.gov/sites/default/files/2023-06-14-wave-2-reeval-public-comment-posting.pdf

Table 1. Cost Measures Considered for Comprehensive Reevaluation

ISO	Cost Measure	Measure Type
1	Acute Kidney Injury Requiring New Inpatient Dialysis	EBCM - Procedural
2	Elective Primary Hip Arthroplasty	EBCM - Procedural
3	Femoral or Inguinal Hernia Repair	EBCM - Procedural
4	Hemodialysis Access Creation	EBCM - Procedural
5	Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	EBCM - Acute Inpatient Medical Condition
6	Lower Gastrointestinal Hemorrhage (at group level only)	EBCM - Acute Inpatient Medical Condition
7	Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	EBCM - Procedural
8	Lumpectomy, Partial Mastectomy, Simple Mastectomy	EBCM - Procedural
9	Non-Emergent Coronary Artery Bypass Graft (CABG)	EBCM - Procedural
10	Renal or Ureteral Stone Surgical Treatment	EBCM - Procedural
11	Medicare Spending Per Beneficiary Clinician	Population-Based Cost Measure
12	Total Per Capita Cost	Population-Based Cost Measure

This document summarizes stakeholder feedback through the public comment process and will inform next steps in the reevaluation process, including conducting any potential additional information gathering and testing to determine the scope of reevaluation or reconvening the Technical Expert Panel and/or Clinician Expert Workgroups, as needed, to discuss stakeholder feedback and other updates.

1.4 Information about the Comments Received

We solicited public comments and conducted education and outreach using the following methods:

- Posted a Call for Public Comment on the CMS Measures Management System (MMS) Current Public Comment Opportunities webpage
- Sent multiple email notifications to Acumen contacts, including targeted outreach to previous participants in measure development and contacts from relevant specialty societies
- Sent multiple email notifications to public listservs, specifically the Quality Payment Program and MMS listservs

  We received 31 comments via email and survey response.

- We received comments from 24 organizations and 10 individuals. Two comments were joint responses from multiple organizations.
- The verbatim text of each submitted comment is presented in Appendix A.

2 STAKEHOLDER COMMENTS: FEEDBACK ON MEASURES

This section summarizes the feedback broadly applicable across multiple measures (Section 2.1) and feedback specific to the measures considered for comprehensive reevaluation (Sections 2.2 – 2.13). It also summarizes feedback received for measures not currently eligible for comprehensive reevaluation (Section 2.14).

2.1 Cross-Cutting Measure Feedback

This section summarizes feedback broadly applicable across multiple measures. Commenters shared input relating to defining episode groups (Section 2.1.1), accounting for patient heterogeneity (Section 2.1.2), attributing episodes to clinicians (Section 2.1.3), assigning costs to episode groups (Section 2.1.4), measure development and maintenance (Section 2.1.5), and information about MIPS cost measures (Section 2.1.6).

2.1.1 Defining Episode Groups

Several commenters expressed support for current trigger code and exclusion specifications, and did not indicate the need for modifications to the patient cohorts for included measures. Some commenters expressed concern about including heterogenous patient populations within a single measure. One commenter suggested excluding episodes from non-cancer EBCMs when a primary cancer diagnosis is present on the patient's trigger claim.

2.1.2 Accounting for Patient Heterogeneity

Commenters supported risk adjustment methodologies that lessen the risk of adverse selection (i.e., selectively choosing patients based on their risk profile). Several commenters stated that risk adjustment variables are appropriate and should continue to be used. Some commenters expressed concern about the potential to manipulate risk adjustment through upcoding of severity. Many commenters provided examples of additional factors that should be considered for risk adjustment, with repeated emphasis on social risk factors and social determinants of health. Other potential factors for risk adjustment discussed included insurance status, frailty, and psychological illness.

One commenter stated that risk adjustment should include HCC codes present on a claim for an outpatient episode or on admission for an inpatient episode (rather than limiting to HCC codes appearing in a lookback period prior to the trigger day). This commenter noted that other risk adjustment models use a one-year window and include codes from the index admission or service. This commenter also recommended that CMS lift limitations on the number of diagnoses that can be included on a given claim.

2.1.3 Attributing Episodes to Clinicians

Several commenters provided feedback on attributing episodes to clinicians. Some commenters noted that cost measures and their corresponding quality measures do not have similar attribution methodologies, which may lead to misalignment in performance measurement. Several commenters noted occasional confusion in understanding how or why an episode was attributed to them (or to clinicians in their organization). Some commenters suggested that certain specialties should be excluded from particular measures, or from all measures not specifically designed for their specialty. One commenter suggested excluding oncologists from attribution for all non-oncology EBCMs. Another commenter stated that there are major problems with attribution, and later stated that the Acute Kidney Injury Requiring New Inpatient Dialysis measure should not be attributed to nephrologists.

2.1.4 Assigning Costs of Services to Episode Groups

Commenters provided feedback on assigning services to episode groups. Several commenters expressed concern about the assignment of costs for services the attributed clinician does not provide or directly control, and for services that are costly yet beneficial to the quality of care.

2.1.5 Measure Development and Maintenance

Several commenters provided general feedback on measure development and maintenance. Commenters expressed appreciation and support for periodic reevaluation of cost measures. Commenters also indicated there was limited information available to assess the cost measures. In particular, several commenters urged caution with reevaluation of the measures, noting limited clinician experience with the measures due to the cost category being reweighted in 2020 and 2021, and citing limited available data about measure performance. In addition to limited data due to cost category reweighting, commenters also noted that care during and following the COVID-19 pandemic may not be representative of standard practice, patient patterns, or normal provider performance.

In particular, commenters provided some recommendations for measure development and maintenance:

- Commenters suggested that CMS should revisit these measures once more data are available, and changes in care patterns due to the COVID-19 pandemic have subsided.
- Commenters suggested that CMS should provide another 30-day comment window when the 2022 QPP Experience Report and Public Use Files are released.
- Commenters stated that cost measures should not rely exclusively on claims data, since such data do not provide a complete picture of patient care, limit the accuracy of cost measures, and are easily impacted by coding practices.

- Cost measures should not evaluate cost in isolation, and should also assess the impact that cost may have on patient outcomes.

Several commenters provided suggestions on clinical areas for development. Some commenters stated that CMS should prioritize measures that are clear and actionable rather than those that have the largest cost coverage. One commenter recommended investigating development of cost measures designed for occupational therapy involvement, in order to better engage occupational therapy clinicians in MIPS and to encompass the wider scope of occupational therapy practice. Another commenter recommended constructing measures for physical therapy clinicians, or modifying existing measures to better include physical therapy clinicians.

Two commenters noted that measure specifications have not been updated to reflect recent changes in Common Procedural Terminology (CPT) codes, and one expressed concern about the use of outdated CPT codes in measure calculation. These commenters identified updates for specific measures to align specifications with the original measure intent. These commenters also recommended that annual maintenance include more frequent and exhaustive review to incorporate coding updates.

2.1.6 Information about MIPS Cost Measures

Several commenters expressed a desire for more information about MIPS cost measures. Several commenters stated that CMS should provide the public with comprehensive analytics regarding the real-world application of these cost measures. Commenters specifically requested information concerning specialties attributed each measure, the average and range of performance on these measures, and number of attributed episodes for each measure. These commenters noted they could not accurately provide input on the measures without such analytics or data.

Commenters noted that individual performance feedback reports are not timely and are difficult to access, and are also difficult to understand. One commenter stated that the lack of timely and useful information on cost measures is their single greatest concern with respect to the MIPS cost category, and that CMS should highly prioritize improving feedback provided on existing cost measures. This commenter supported providing data on regular and predetermined intervals and including measure specifications in clinician feedback reports, and that data reporting be included as a topic for periodic review or reevaluation (alongside the measures themselves). This commenter stated that clinicians and groups should be provided with sufficient cost data to validate their own performance scores.

2.2 Acute Kidney Injury Requiring New Inpatient Dialysis

Three commenters provided feedback on the Acute Kidney Injury Requiring New Inpatient Dialysis measure. One commenter supported the measure as currently specified. Other commenters provided suggestions around attribution, with one commenter stating that the measure should not be attributed to nephrologists, and another expressing concern about the attribution of the measure to the nephrologist treating a beneficiary in the hospital setting, stating that follow-up care is undertaken by a different nephrologist practice. One commenter also noted that the measure should account for social risk factors in the patient population, and should also account for patients' chronic kidney disease severity. A commenter stated that the measure may not be a meaningful assessment of physician care since cost may have less to do with the physician than the patient, as duration of acute kidney injury is a major driver of cost.

2.3 Elective Primary Hip Arthroplasty

Two commenters provided feedback on the Elective Primary Hip Arthroplasty measure. The first commenter expressed support for the measure, and also indicated support for risk adjustment for social risk factors. The second commenter provided specific recommendations on updating physical therapy CPT codes included in service assignment, and recommended the addition of several physical therapy CPT codes for service assignment.

2.4 Femoral or Inguinal Hernia Repair

No feedback specific to the Femoral or Inguinal Hernia Repair measure was received during the public comment period.

2.5 Hemodialysis Access Creation

Two commenters provided feedback on the Hemodialysis Access Creation measure. Both commenters expressed support for the measure and/or its specifications (including the trigger, exclusion, and risk adjustment methodologies). One commenter also proposed the addition of several factors to risk adjustment, including number of previous and failed fistulas or grafts, and catheterization at initiation of dialysis. This commenter also stated that interventional radiologists would only be involved in creation of a fistula, whereas a vascular surgeon would be required to create a graft.

2.6 Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation

Two commenters provided feedback on the Inpatient COPD Exacerbation measure. One commenter recommended addition of several physical therapy CPT codes to service assignment. Another commenter expressed support for assessing cost measurement and quality together, as they expressed concern about the measure's assessment of cost without concurrent assessment of care quality or other quality outcomes. This commenter also stated that some post-acute care

may be costly but has substantial value for improving patient outcomes, including quality of life. This commenter cited that some studies have shown that reducing readmissions may not lead to reduced mortality or other improved quality outcomes. They also expressed concern about the use of fixed diagnostic related group (DRG) reimbursement amounts to represent the cost of the inpatient stay, and noted that this may make it difficult for the measure to capture differences in length of inpatient stay.

2.7 Lower Gastrointestinal Hemorrhage

The public comment posting document and public comment survey included a question specific to the Lower Gastrointestinal Hemorrhage measure to gather input on the potential of refining the measure scope to increase the number of episodes and impact inpatient non-surgical gastrointestinal care. In particular, the posting document and survey requested feedback about inclusion of upper gastrointestinal hemorrhage and sub-grouping between upper and lower hemorrhage. Three commenters provided feedback on the Lower Gastrointestinal Hemorrhage measure, and all three commenters provided feedback concerning measure scope.

Two commenters expressed support for an expanded measure scope in some capacity. One commenter suggested including radiation proctitis/enteritis as a diagnosis code for the measure, since it may present as lower gastrointestinal bleeding. Another commenter expressed support of an expanded measure scope by way of including non-variceal upper gastrointestinal hemorrhage in the measure and establishing sub-groups between upper and lower hemorrhage. This commenter did note that etiologies, locations, and therapies differ between the two conditions, and that distinguishing between the two using sub-groups is therefore critical. This commenter stated that including both upper and lower hemorrhage in a single measure would allow for additional risk prevention for patients at higher risk of bleeding, while use of sub-grouping would help to preserve the technical integrity of the measure.

One commenter expressed support for the measure as currently specified, and strongly opposed expanding the scope of the measure to include upper gastrointestinal hemorrhage. This commenter noted that the patient population, etiology, and care approaches differ substantially between upper and lower hemorrhage. This commenter proposed that expanding the measure would introduce unnecessary complexities to measure construction, and may also make the measure more difficult to understand for gastroenterologists subject to the measure. This commenter recommended that CMS reconvene the workgroup involved in measure development to vet public input prior to making substantial revisions to the measure.

2.8 Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels

Three commenters provided feedback on the Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels, measure. Two commenters expressed general support for the measure and stated that

the measure appears reasonably specified. One commenter requested clarification on the methodology for inclusion of cost for physical therapy services in the measure.

One commenter provided specific feedback on the measure's service assignment rules, noting that the measure includes cost outside the attributed clinician's control, such as Skilled Nursing Facility (SNF) stays. This commenter also expressed concern that inclusion of services such as pain management would amount to penalization of use of those services. This commenter also provided input on risk adjustment, recommending the inclusion of mental health conditions, psychiatric indications, and social risk factors in risk adjustment, and expressed concern about the potential for adverse selection absent these factors. This commenter also stated that the current risk adjustment model may incentivize upcoding, in which providers would code more severe diagnoses than are actually applicable to their patients.

One commenter suggested providing additional data to the public as part of this public comment period to better help inform feedback, and also recommended revisiting the measure after the impact of the COVID-19 pandemic has subsided and care patterns have normalized.

2.9 Lumpectomy, Partial Mastectomy, Simple Mastectomy

Two commenters provided feedback on the Lumpectomy, Partial Mastectomy, Simple Mastectomy measure. The first commenter expressed support for the measure, and stated it appears appropriate and beneficial. One commenter stated that they could not provide feedback on the measure at this point in time and recommended revisiting the measure once more data are available, noting that limited data had been released about the measure's use and that it was therefore difficult to assess the impact of the measure given the effects of the COVID-19 pandemic.

2.10 Non-Emergent Coronary Artery Bypass Graft (CABG)

Four commenters provided feedback on the Non-Emergent Coronary Artery Bypass Graft (CABG) measure.

The first commenter noted that non-emergent CABG is increasingly considered a less useful procedure, with fewer indications than the past, citing the ISCHEMIA trial as evidence. The second commenter recommended the addition of several codes indicative of an emergent CABG to the exclusions list. The third commenter provided feedback on sub-groups for Non-Emergent CABG. This commenter stated that reconsideration of the Non-Emergent CABG with Aortic Valve Replacement (AVR) sub-group may be warranted, given the existence of composite measures that pair Non-Emergent CABG with valve procedures. This commenter also suggested that adding a sub-group for Mitral Valve Replacement may be worthwhile, while noting

variability in practice patterns and cost. The fourth commenter requested clarification on circumstances in which physical therapy codes would be included in the measure.

2.11 Renal or Ureteral Stone Surgical Treatment

Two commenters provided feedback on the Renal or Ureteral Stone Surgical Treatment measure. The first commenter noted increased frequency of combined treatment procedures and suggested a sub-group for combined procedures, and stated the measure is otherwise appropriate and well-constructed. The second commenter stated that the trigger, exclusion, and risk adjustment methodologies are appropriate and well-constructed. This commenter suggested the addition of the following factors to risk adjustment: disease greater than 12 months, prior nephrolithotomy on the same side, the degree of hydronephrosis, stone size, and number of stones.

2.12 Medicare Spending Per Beneficiary (MSPB) Clinician

This section summarizes feedback on the Medicare Spending Per Beneficiary (MSPB) Clinician measure. Seven commenters submitted feedback on the MSPB Clinician measure. The following subsections describe feedback received about attribution and eligible clinicians (Section 2.12.1), the measure's effect on different specialties (Section 2.12.2), and other recommended changes to the measure's construction (Section 2.12.3).

2.12.1 Attribution and Included Clinicians

Several commenters perceived that providers are being attributed costs of care over which they have little influence. One commenter suggested that emergency physicians are not the physicians who are driving the cost of care during a hospital stay and are often unaware they are being attributed, and should therefore be removed from MSPB Clinician attribution. Another commenter recommended removing interventional radiologists from the measure, stating these providers do not drive care plans in hospitals or post-discharge. Additionally, one commenter noted that for some surgical DRGs, clinicians caring for the main disease process typically drive care for the patient as opposed to the proceduralist who performed the primary procedure.

To create a more reasonable attribution methodology for drivable costs, one commenter suggested promoting the use of virtual groups. Another commenter recommended attribution at the TIN level rather than the TIN-NPI level, stating that quality is not always tied to better care from an individual clinician.

2.12.2 Specialty-Specific Effects

One commenter raised concerns that the MSPB Clinician measure does not account for variation in costs by specialty. The commenter requested consideration of specialty-specific recalibration as a means to prevent payment penalties to certain specialties.

Some commenters proposed that the MSPB Clinician measure does not adequately adjust for the resources necessary to deliver cancer care, which negatively impacts oncologists' MIPS scores. One commenter stated that the current MSPB Clinician methodology inflates costs for medical oncology practices by failing to exclude patients who are on active chemotherapy treatment. The commenter recommended excluding all Medicare Part B drug costs associated with chemotherapy treatment and considering specialty-specific benchmarking to avoid variable cost measure scoring across specialties. Another commenter supported the exclusion of chemotherapy-related expenses from the costs assigned to clinicians under MSPB Clinician.

2.12.3 Other Feedback on the MSPB Measure

The remaining feedback on the MSPB Clinician measure is summarized below and covers various aspects of the measure's construction:

- One commenter stated that attribution to multiple clinicians/clinician groups leaves clinicians with little information on how to better coordinate care and improve resource use. This commenter suggested that reports with actionable data be distributed to providers to improve patient care and costs.
- One commenter recommended that patient perspective be incorporated into the measure, potentially through the use of advanced analytic models to predict patient readmission risk and guide intervention strategies.
- Two commenters expressed concern that clinicians are double counted for their performance, with costs captured in both MSPB and another cost measure. One commenter suggested that clinicians attributed both EBCMs and MSPB be excluded from MSPB.
- One commenter stated that social risk factors should be accounted for in the measure's risk-adjustment models. This commenter recommended the use of the Area Deprivation Index (ADI) if social risk factor data is not available in claims.
- One commenter stated that the CPT coding specifications for this measure should be updated. The commenter was concerned that outdated measure specifications will impact the reliability and validity of the measure, and may lead to inaccurate measure results. Another commenter proposed that codes for the surgical attribution tab of the MSPB Clinician measure are inaccurate.

2.13 Total Per Capita Cost

This section summarizes the feedback on the Total Per Capita Cost (TPCC) measure. The following subsections describe feedback received about attribution, included clinicians, and clinician exclusions (Section 2.13.1); identifying the beginning and end of primary care relationships (Section 2.13.2); and other recommended changes to the measure's construction (Section 2.13.3).

2.13.1 Attribution, Included Clinicians, and Clinician Exclusions

Some commenters recommended specialties that should be included in TPCC attribution. One commenter provided feedback on the inclusion of cardiology services in the TPCC measure, recommending that only care for certain conditions such as heart failure, coronary artery disease, refractory hypertension, cardiac arrhythmias, and congenital heart disease be included for this measure. One commenter recommended including physical therapists within the measure scope, and also expressed concern about excluding clinicians based on HCFA specialty. This commenter suggested that exclusion should be based on provider type and the provider's ability to provide and bill services independently. One commenter indicated that surgical and diagnostic providers are attributed patients under the TPCC measure, despite not carrying out primary care services. The commenter proposed that although these providers bill E&M codes, they are not responsible for managing chronic conditions and typically perform poorly because they are being held accountable for services and outcomes that are outside of their scope.

Several commenters noted that service category and HCFA exclusions should be revisited in the TPCC measure's attribution methodology to better reflect clinicians responsible for primary care management. One commenter recommended excluding oncology as an eligible specialty for the TPCC measure using the HCFA designation. This commenter voiced support for specialty-based exclusion that is not reliant upon a certain percentage of candidate events being comprised of chemotherapy services. Another commenter recommended that emergency physicians be excluded from the TPCC measure because the measure does not accurately represent the performance of emergency physicians.

One commenter questioned exclusions at the specialty level. They proposed a scenario where a practice comprised of excluded specialists may still be attributed if the practice also uses a Physician Assistant or Nurse Practitioner who provides an E&M visit and another primary care service, holding clinicians responsible for costs they cannot control.

Commenters suggested refining TPCC candidate event trigger logic to consider which services capture primary care management. Several commenters suggested excluding clinicians (such as Physician Assistants, Nurse Practitioners and Clinical Nurse Specialists) in a TIN where the plurality of clinicians is excluded specialists. One commenter also suggested excluding patients who are on active chemotherapy as well as ensuring all infused and oral chemotherapy agents (Medicare Part B and Part D) are considered when assessing whether a clinician has more than 10% of candidate events tied to chemotherapy treatment.

2.13.2 Identifying the Beginning and End of Primary Care Relationships

Two commenters expressed that clinicians should not be responsible for costs that have occurred long after seeing a patient nor after the patient has moved to another city or state. One

commenter does not support attributing the same costs to multiple clinicians in different practices when there is no evidence that these clinicians are coordinating care together. This commenter also noted that the current TPCC methodology does not identify the end of a clinician's primary care responsibility, explaining that even after a patient moves to a different practice or moves out of state, a clinician can be attributed costs related to their care despite the patient no longer living in the community.

One commenter described a number of issues that may arise from the way TPCC attribution identifies primary care relationships, including scenarios where clinicians may refuse primary care visits for pre-surgical clearance or may be less likely to schedule follow-up visits with patients with more complex health histories in an attempt to avoid attribution of the measure.

2.13.3 Other Feedback on the TPCC Measure

The remaining feedback on the TPCC measure is summarized below and covers various aspects of the measure's construction:

- One commenter requested clarification on if oncology physician documentation and coding in the risk adjustment will be considered for individuals attributed the TPCC measure in the oncology MIPS Value Pathway (MVP).
- One commenter expressed concerns over the TPCC measure's validity. This commenter also noted that the measure does not account for social factors in its risk adjustment model.
- One commenter expressed concern that clinicians are double counted for their performance, with costs captured in both TPCC and another cost measure.
- Several commenters noted that since the measure relies on retrospective claims data, there is a delay in the TPCC measure's ability to provide timely feedback to health care providers, which interferes their ability to identify and address cost drivers promptly.
- Several commenters stated that the TPCC measure should only cover costs that physicians can reasonably influence.
- One commenter stated that the CPT coding specifications for this measure should be updated. The commenter was concerned that outdated measure specifications will impact the reliability and validity of the measure, and may lead to inaccurate measure results.

2.14 Feedback on Measures Not Eligible for Comprehensive Reevaluation

This section summarizes feedback received for measures not currently eligible for comprehensive reevaluation. Several commenters provided feedback on measures introduced to MIPS in performance year 2022, with multiple comments on the chronic condition measures

Asthma/COPD and Diabetes (Section 2.2.1), and one comment on Sepsis (Section 2.2.2). These measures were not part of the public comment posting and are not currently eligible for comprehensive reevaluation, but feedback received is included in this report for clarity and transparency.

2.14.1 Asthma/COPD and Diabetes

Several commenters provided feedback on attribution for the Asthma/COPD and Diabetes measures, which are chronic condition measures first used in MIPS in performance year 2022. Two commenters stated that ophthalmologists should not be attributed the Diabetes measure. One of these commenters also noted that there are different methodologies for attribution at the group and individual reporting levels. Two other commenters stated that they had identified instances of oncologists attributed Asthma/COPD and/or Diabetes cost measures, despite not providing care for those conditions. One of these commenters expressed concern that including diagnoses for comorbidities may trigger chronic condition episodes, and also identified several services included in trigger codes that they believe are either not related to chronic condition care or that may be ordered for unrelated purposes.

2.14.2 Sepsis

One commenter provided feedback on the Sepsis measure, which was first used in MIPS in performance year 2022. This commenter suggested revision of the Sepsis subgroups to account for organ dysfunction, as distinct from shock.

3 OVERALL ANALYSIS AND RECOMMENDATIONS

We appreciate and have carefully considered the responses collected from the public comment period for the re-evaluation of the ten cost measures originally developed in Wave 2 as well as Medicare Spending Per Beneficiary (MSPB) Clinician and Total Per Capita Cost (TPCC). We considered all the feedback received during the public comment period and conducted empirical analyses to evaluate and further explore the potential direction for reevaluating measures. Based on feedback from relevant stakeholders, empirical analyses, and agency priorities, CMS has approved the TPCC measure to undergo a comprehensive reevaluation process.

To revise TPCC, the PCMP Technical Expert Panel will provide input concerning attribution rules for defining patient-care relationships. This input will assist CMS in determining necessary modifications to measure specifications in order to fulfill program needs.

CMS carefully considered the substantial feedback received for all measures, and the remaining eleven cost measures will be eligible for consideration during a future wave of reevaluation. All measures will also continue to be maintained as usual through the annual maintenance process; this typically involves coding updates to reflect any new or different codes that are released during the year. We also encourage interested parties to reach out to the QPP Service Center (QPP@cms.hhs.gov) or email macra-cost-measures-info@acumenllc.com with feedback about measure specifications so that we can consider this in any future maintenance or reevaluation activities for any of the measures in the MIPS cost performance category.

APPENDIX A: PUBLIC COMMENT VERBATIM REPORT

This appendix contains the verbatim texts of the comments received. The information is provided in a list format and presented in order of the comment number, or assigned identification number for the comment. The list presents the name, affiliated organization, and date of submission (date of receipt of the comment via email or survey submission). The submitter name for each comment is the name of the person who submitted the letter or filled out the survey. For some comment submissions, the person who signed the comment letter is not the same as the person who submitted the comment nor the same as the contact person provided in the comment.

Please note that the verbatim text has been edited to improve the readability of this report. We omitted letter template details (e.g., company logo), email signatures, and sensitive personally identifiable information (e.g., phone numbers and email addresses). Also, respondents' complete survey responses were concatenated together.

3.1 List of Verbatim Comments

3.1.1 Comment Number 1

- **Date:** 7/13/2023
- **Submitter Name, Credentials, and Organization:** Ivory Harding, National Kidney Foundation
- **Comment Text:**

[1.4.1. Should there be any changes to the patient cohort for the measures, as defined by trigger codes and exclusions? For instance, given the set of cost measures in MIPS, are there any gaps in care that could appropriately be filled by expanding the scope of an existing measure? Has clinical practice changed how these conditions and procedures are performed in a way that the patient cohort would need updating?]

The National Kidney Foundation supports the patient cohort for the Acute Kidney Injury Requiring New Inpatient Dialysis and the Hemodialysis Access Creation measures as they are currently defined.

[1.5.2. Are there any updates that should be made to the measure-specific risk adjustors, such as to reflect changes in clinical practice or to align with other cost measures used in MIPS?]

The National Kidney Foundation supports the measure-specific risk adjustors for the Acute Kidney Injury Requiring New Inpatient Dialysis and the Hemodialysis Access Creation measures as they are currently defined.

[3.1. Please provide your feedback for the Acute Kidney Injury Requiring New Inpatient Dialysis measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

The National Kidney Foundation supports the Acute Kidney Injury Requiring New Inpatient Dialysis cost measure.

[6.1. Please provide your feedback for the Hemodialysis Access Creation measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

The National Kidney Foundation supports the Hemodialysis Access Creation cost measure.

3.1.2 Comment Number 2

- **Date:** 7/13/2023
- **Submitter Name, Credentials, and Organization:** Maria Mazzoccoli, Consulting Ophthalmologists PC
- **Comment Text:**

[6.1. Please provide your feedback for the Hemodialysis Access Creation measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

Many times we are attributed to patients who's major costs come from elsewhere, for example, Diabetic patients. It would be helpful if we could more easily determine who would be attributed to us as well as what costs would be attributed to us so we may have a better understanding of our scores.

3.1.3 Comment Number 3

- **Date:** 7/11/2023
- **Submitter Name, Credentials, and Organization:** Vicky Whelchel, National Association of Clinical Nurse Specialists
- **Comment Text:**

[10.1. Please provide your feedback for the Lumpectomy, Partial Mastectomy, Simple Mastectomy measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

The measures taken appear to be appropriate and beneficial to patient and provider documentation/payment.

3.1.4 Comment Number 4

- **Date:** 7/14/2023
- **Submitter Name, Credentials, and Organization:** Daniel Weiner, Individual

- **Comment Text:**

[1.4.1. Should there be any changes to the patient cohort for the measures, as defined by trigger codes and exclusions? For instance, given the set of cost measures in MIPS, are there any gaps in care that could appropriately be filled by expanding the scope of an existing measure? Has clinical practice changed how these conditions and procedures are performed in a way that the patient cohort would need updating?]

I think there remains major issues with attribution. As an aside, the link to the QPP library sends to a page with a terrible search feature, making looking up specific measure specifications very difficult.

[3.1. Please provide your feedback for the Acute Kidney Injury Requiring New Inpatient Dialysis measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

For the AKI measure, it worries me that this will result in therapeutic nihilism on performing surgery and other procedures in people with advanced CKD. Given the higher prevalence of advanced CKD in persons of color and people with fewer socioeconomic advantages, I worry that this will further exacerbate access to care for vulnerable individuals. This is troubling. There needs to be sufficient accounting for AKI-D risk - eGFR actual values and albuminuria (kidney damage indicator) at baseline. There is tremendous heterogeneity within CKD stages in kidney risk that is not addressed in this metric. This measure should NOT be attributed to nephrologists. Happy to discuss further, but nephrologists are typically not involved in this phase of care.

3.1.5 Comment Number 5

- **Date:** 7/14/2023
- **Submitter Name, Credentials, and Organization:** Jennifer Eckerman, Individual
- **Comment Text:**

[1.4.1. Should there be any changes to the patient cohort for the measures, as defined by trigger codes and exclusions? For instance, given the set of cost measures in MIPS, are there any gaps in care that could appropriately be filled by expanding the scope of an existing measure? Has clinical practice changed how these conditions and procedures are performed in a way that the patient cohort would need updating?]

No

[1.5.2. Are there any updates that should be made to the measure-specific risk adjustors, such as to reflect changes in clinical practice or to align with other cost measures used in MIPS?]

No

3.1.6 Comment Number 6

- **Date:** 7/14/2023
- **Submitter Name, Credentials, and Organization:** Lloyd Klein, Society for Cardiovascular Angiography and Interventions
- **Comment Text:**

[1.4.1. Should there be any changes to the patient cohort for the measures, as defined by trigger codes and exclusions? For instance, given the set of cost measures in MIPS, are there any gaps in care that could appropriately be filled by expanding the scope of an existing measure? Has clinical practice changed how these conditions and procedures are performed in a way that the patient cohort would need updating?]

When triggers are non-voluntary, ie due to a complication, the only mechanism to bring in a consultant requires payment of their services or why would they respond? Cost cutting in emergencies is not the way to go.

[1.5.2. Are there any updates that should be made to the measure-specific risk adjustors, such as to reflect changes in clinical practice or to align with other cost measures used in MIPS?]

Age

Frailty

Insurance Coverage

[11.1. Please provide your feedback for the Non-Emergent Coronary Artery Bypass Graft (CABG) measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

Cabg has been downgraded since these measures were constructed. It is now less indicated than it the past and for fewer indications. This whole measure needs to be reassessed in light of the ISCHEMIA Trial."

3.1.7 Comment Number 7

- **Date:** 7/17/2023
- **Submitter Name, Credentials, and Organization:** Jana Gilbert, Individual
- **Comment Text:**

[1.4.1. Should there be any changes to the patient cohort for the measures, as defined by trigger codes and exclusions? For instance, given the set of cost measures in MIPS, are there any gaps in care that could appropriately be filled by expanding the scope of an existing measure? Has clinical practice changed how these conditions and procedures are performed in a way that the patient cohort would need updating?]

The reasoning as to why diabetics are being counted for the group measure in ophthalmology should be looked at. Ophthalmologists do not manage diabetes and do not prescribe diabetic medications. We do comprehensive eye exams for diabetic patients. Since they are not our patient to manage, their cost should not be associated with ophthalmologists reporting as groups.

3.1.8 Comment Number 8

- **Date:** 7/17/2023
- **Submitter Name, Credentials, and Organization:** James S Kennedy MD, VP-MA Health Solutions dba CDIMD
- **Comment Text:**

[1.4.1. Should there be any changes to the patient cohort for the measures, as defined by trigger codes and exclusions? For instance, given the set of cost measures in MIPS, are there any gaps in care that could appropriately be filled by expanding the scope of an existing measure? Has clinical practice changed how these conditions and procedures are performed in a way that the patient cohort would need updating?]

I believe that the inpatient cost measure for sepsis should be redefined, given that there is no concrete definitions of sepsis without organ dysfunction, sepsis with organ dysfunction but without shock, and sepsis with shock. Since these are dependent on provider documentation and ICD-10-CM coding, I believe that you need three subsets within the sepsis cohort as described above, not the two (sepsis without shock; sepsis with shock) that you have today. Also, the organ dysfunctions can be coding defined without necessarily requiring a code for severe sepsis, such as metabolic encephalopathy, acute kidney failure, thrombocytopenia, etc., which I can help you write. We can also include vasopressor use as a surrogate for septic shock; however, the hospitals would have to code it. I can help you with this if you wish. My telephone number is *[redacted]*.

[1.5.2. Are there any updates that should be made to the measure-specific risk adjustors, such as to reflect changes in clinical practice or to align with other cost measures used in MIPS?]

I believe that the risk adjustment should include HCC codes that are present on a claim for an outpatient episode model or that are present on admission for an inpatient episode model. Today, you only count codes that are collected 120 days PRIOR TO the episode model (except MSPB which is 90 days) as to exclude codes that are coded on the triggering inpatient or outpatient claim. Know that CMS's Yale models for mortality, readmission, and quality use codes collected within one year of the triggering inpatient event or those captured on the index admission that are present on admission. Also, you need to let us know if you will use version 24 or version 28 HCCs in your risk adjustment. Physicians need to be able to report more than 12 diagnoses that risk-adjust on their outpatient claims; you must advocate that the current limitations with the 5010 be expanded. As to inhibit gaming, I believe that for encounters that have an abstracted database, such as STS for cardiac surgery or NCDR for interventional cardiology, you can inhibit gaming if you allow their metrics to be substituted for coded data which, as with know with Medicare Advantage plans, can be subject to gaming whereas STS is not.

[6.1. Please provide your feedback for the Hemodialysis Access Creation measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

Please call me if you need to discuss documentation and coding principles.
[11.1. Please provide your feedback for the Non-Emergent Coronary Artery Bypass Graft (CABG) measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

You need to add ALL the MI codes that are present on admission as qualifying the patient for having an emergency CABG. Under today's coding rules, if a patient has a type 2 or type 4-related STEMI, we cannot report these with I21.0-I21.3 codes; we must use I21.A9 which does NOT exclude this episode. In addition, many patients present with an acute type 1 NSTEMI that requires CABG that is coded as I21.4 which is not on your list. Finally, you do not include at all any of the I22.xx codes that can be used if the previous MI was a type 1 STEMI or NSTEMI. Last but not least, some patients can have both a type 1 and type 2 mechanism for their acute MI for which a CABG is indicated. Maybe you accounted for this with the cardiac catheterization exclusions. In addition, you need to include ALL shock codes in R79.x as well as septic shock, R65.21 which can have a cardiogenic component due to the myocardial suppressant factor.

[14.1. The measure currently uses exclusions based on both services and HCFA Specialty to ensure that the measure only captures clinicians who provide primary care or care across multiple conditions. The advantage of service category exclusions is that it focuses on the care actually provided by clinicians, since HCFA Specialty lacks granularity for subspecialties who may provide different types of care. The disadvantage is that these definitions are more complex than HCFA Specialty exclusions. Should the measure use only one type of exclusion rule to simplify the specifications? If so, which exclusion method should be used and why?]

From what I understand, you are using the TPCC with an oncology MIPS value pathway. Can you advise if you will include oncology physician documentation and coding in the risk adjustment for this population, not just those of primary care physicians?

3.1.9 Comment Number 9

- **Date:** 7/18/2023
- **Submitter Name, Credentials, and Organization:** Cynthia Allen, Zuleika M. Ghodsi, MD, PC dba. Delmarva Laser Eye Center
- **Comment Text:**

[1.4.1. Should there be any changes to the patient cohort for the measures, as defined by trigger codes and exclusions? For instance, given the set of cost measures in MIPS, are there any gaps in care that could appropriately be filled by expanding the scope of an existing measure? Has clinical practice changed how these conditions and procedures are performed in a way that the patient cohort would need updating?]

Diabetes Measure ID COST_D_1 cost reduction for ophthalmologist's who do not and cannot manage a patient's overall diabetes care. In addition there are different attribution methodology for the Diabetes Cost Measure for practices reporting MIPS at the group vs. individual level. [1.5.2. Are there any updates that should be made to the measure-specific risk adjustors, such as to reflect changes in clinical practice or to align with other cost measures used in MIPS?]

Diabetes Measure ID COST_D_1 cost reduction for a Ophthalmologist is inappropriately attributed to this measure as it is not in their scope-of-practice.

3.1.10 Comment Number 10

- **Date:** 7/18/2023
- **Submitter Name, Credentials, and Organization:** Amy Beckrich, Renal Physicians Association
- **Comment Text:**

[3.1. Please provide your feedback for the Acute Kidney Injury Requiring New Inpatient Dialysis measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

RPA believes that patient level variability in acuity/intensity of care required can make this measure a non-meaningful assessment of physician care â€“ i.e., the cost may have less to do with the physician than the patient as duration of AKI is a major driver of the cost. Furthermore, RPA has strong concerns regarding attribution of this measure: the episode is attributed to the nephrologist(s) who sees the patient in the hospital when dialysis begins. When examining claims data, the majority of these patients are cared for by a different nephrology practice when they leave the hospital. RPA believes it is not appropriate to hold the physician who provided care during the inpatient stay accountable for care that happens on an outpatient basis when the patient is typically under the care of a different nephrology practice. Therefore, RPA does not support this measure.

3.1.11 Comment Number 11

- **Date:** 7/19/2023
- **Submitter Name, Credentials, and Organization:** Todd Garvin, American Urological Association
- **Comment Text:**

[12.1. Please provide your feedback for the Renal or Ureteral Stone Surgical Treatment measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

It seems there are an increasing number of patients receiving combined treatment procedures (ESWL and ureteroscopy, or percutaneous and ureteroscopic stone removal). There should be a

defined sub-group for combined procedures, to capture them, rather than excluding them or grouping them with the single highest-line procedure.

Otherwise, I feel the cost measure is appropriate and well-constructed.

3.1.12 Comment Number 12

- **Date:** 7/20/2023
- **Submitter Name, Credentials, and Organization:** Donna Kucharski MD, SCH
- **Comment Text:**

[1.4.1. Should there be any changes to the patient cohort for the measures, as defined by trigger codes and exclusions? For instance, given the set of cost measures in MIPS, are there any gaps in care that could appropriately be filled by expanding the scope of an existing measure? Has clinical practice changed how these conditions and procedures are performed in a way that the patient cohort would need updating?]

Reviewing the list of trigger codes I have updated March 2022 I do not believe any changes are required.

I do not think clinical practice has changed- however- development of quality measures- specifically the composite measures for cardiac surgery- brings into question the use of the subgroup cabg with AVR.

I do not know the current rationale- there are however multiple composite measures, pairing NE CABG with valve R/r procedures.

Greater clarity may be gained by limiting the group to NE CABG without the AVR subgroup. This could serve as a baseline as cost measures may be considered for some or all of the composite measures pairing NE CABG with one or more valvular procedures.

[1.5.2. Are there any updates that should be made to the measure-specific risk adjustors, such as to reflect changes in clinical practice or to align with other cost measures used in MIPS?]

I don't know that I am qualified to speak to this question.None that I know of.

[11.1. Please provide your feedback for the Non-Emergent Coronary Artery Bypass Graft (CABG) measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

Given my earlier comments about separation of the neCABG and the neCABG with AVR, sufficient development of the model methodology may have been experienced for the ability to add a second type of valve.

As the rick and morbidity associated with MVR/r is most significant, This might be the next subgroup to add. Practice variability and cost differentials between sites may pose significant

hurdles to making this a meaningful subgroup. It is possible that documentation of those hurdles would be very informative.

3.1.13 Comment Number 13

- **Date:** 7/21/2023
- **Submitter Name, Credentials, and Organization:** Helen Gelly, Undersea and Hyperbaric Medical Society
- **Comment Text:**

[8.1.1. What are ways to refine the measure scope to increase the number of episodes and be impactful inpatient non-surgical gastrointestinal care? For example, would it be appropriate to include upper gastrointestinal hemorrhage in the measure and sub-group between upper and lower hemorrhage? Why or why not? Are there other similar conditions under a different MS-DRG that could be included in the measure?]

Include radiation proctitis/enteritis as a diagnosis code as this presents as lower GI bleed however might not be coded as such since there is a different etiology in many cases

3.1.14 Comment Number 14

- **Date:** 7/21/2023
- **Submitter Name, Credentials, and Organization:** Robert Sterling, American Association of Hip and Knee Surgeons
- **Comment Text:**

[4.1. Please provide your feedback for the Elective Primary Hip Arthroplasty measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

The American Association of Hip and Knee Surgeons continues to support inclusion of Elective Primary Hip Arthroplasty as a population based MIPS Cost Measure. Due to the socioeconomic and racial diversity of Medicare patients who undergo total hip replacement and the known influence that socioeconomic status and race can have on the cost of care, we would support inclusion of this into the risk stratification model which could be done through consideration of dual eligibility status as has been proposed and done for other risk adjustment models or another appropriate means of population based risk stratification.

3.1.15 Comment Number 15

- **Date:** 7/19/2023
- **Submitter Name, Credentials, and Organization:** Jeffrey Silberzweig, Individual
- **Comment Text:**

[1.4.1. Should there be any changes to the patient cohort for the measures, as defined by trigger codes and exclusions? For instance, given the set of cost measures in MIPS, are there any gaps in

care that could appropriately be filled by expanding the scope of an existing measure? Has clinical practice changed how these conditions and procedures are performed in a way that the patient cohort would need updating?]

No

[1.5.2. Are there any updates that should be made to the measure-specific risk adjustors, such as to reflect changes in clinical practice or to align with other cost measures used in MIPS?]

No

3.1.16 Comment Number 16

- **Date:** 7/19/2023
- **Submitter Name, Credentials, and Organization:** Piyush N Joshi, American Urological Association
- **Comment Text:**

[1.4.1. Should there be any changes to the patient cohort for the measures, as defined by trigger codes and exclusions? For instance, given the set of cost measures in MIPS, are there any gaps in care that could appropriately be filled by expanding the scope of an existing measure? Has clinical practice changed how these conditions and procedures are performed in a way that the patient cohort would need updating?]

No

[1.5.2. Are there any updates that should be made to the measure-specific risk adjustors, such as to reflect changes in clinical practice or to align with other cost measures used in MIPS?]

No

3.1.17 Comment Number 17

- **Date:** 7/21/2023
- **Submitter Name, Credentials, and Organization:** Laura Feemster, Individual
- **Comment Text:**

  We queried members of the American Thoracic Society Quality Improvement and Implementation Committee regarding the Inpatient COPD Exacerbation Measure. The group's concerns center around that fact that costs for this measure are being evaluated in the absence of assessment of care quality or outcomes (other than readmission). Specific concerns include:

  1) Inpatient "costs" are defined by the DRG reimbursement (resulting in a fixed reimbursement amount) and therefore don't reflect actual costs or even resource use. So, a provider could be innovative and high quality, getting patients out of the hospital quickly, but at the cost of more outpatient encounters to do so safely, thereby saving money since inpatient costs contribute the most to the overall episode actual cost. Because of the increased outpatient costs, they would be identified as higher cost by this measure, even though the opposite is true.

2) The measure includes costs of post-acute rehabilitation, which may include pulmonary rehabilitation. Pulmonary rehabilitation has been shown to reduce risk of readmission and improve symptoms and quality of life among patients with COPD. Yet providers who consistently provide this evidence-based care may be unfairly penalized for increased costs despite providing higher quality of care.

3) The measure seems to incentivize clinicians to reduce readmissions following a hospitalization for a COPD exacerbation, yet there is a lack of evidence that reducing readmissions leads to improved care quality or outcomes. In fact, in at least one recent large study of Medicare beneficiaries hospitalized for COPD exacerbation between 2006-2017 demonstrated a reduction in 30-day readmissions and an increase in 30-day mortality rates (Neira DA, Hsu ES, Kuo Y, et al. Readmissions reduction program: mortality and readmissions for chronic obstructive pulmonary disease. Am J Respir Crit Care Med. 2021;203(4)437-446). These findings are consistent with prior studies following hospitalization for heart failure as well.

3.1.18 Comment Number 18

- **Date:** 7/21/2023
- **Submitter Name, Credentials, and Organization:** Erin Grossmann, American College of Emergency Physicians
- **Comment Text:**

July 21, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 816
Baltimore, MD 21244

Re: MACRA Cost Measures: Call for Public Comment for Measure Reevaluation

Dear Administrator Brooks-LaSure:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on MACRA Cost Measures: Call for Public Comment for Measure Reevaluation.

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC, to develop and maintain cost measures for clinicians and clinician groups. Participants in the Merit-based Incentive Payment System (MIPS) receive an adjustment to their Medicare payments based on a final score that assesses evidence-based and practice-specific data in 4 performance categories: (i) quality, (ii) cost, (iii) improvement activities, and (iv) promoting interoperability.

In performance year 2023, the MIPS cost performance category has 23 episode-based cost measures and 2 population-based cost measures which have been gradually added over the past years.

The measure maintenance process allows developers to ensure measures continue to function as intended and to consider refinements to the measure. Every three years, measures are considered for comprehensive reevaluation, during which measure developers can more holistically review the measure, seek public comment, and consider many aspects of the measure specifications, not just the updates done through annual maintenance.

The first cycle of comprehensive reevaluation for MIPS cost measures began in early 2022, with a public comment period on eight episode-based cost measures first added to the MIPS cost performance category in performance year 2019. Acumen, LLC is now seeking public comment on a second cycle of comprehensive reevaluation for

MIPS cost measures. The following twelve cost measures are being considered for comprehensive reevaluation:

- Acute Kidney Injury Requiring New Patient Dialysis
- Elective Primary Hip Arthroplasty
- Femoral or Inguinal Hernia Repair
- Hemodialysis Access Creation
- Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
- Lower Gastrointestinal Hemorrhage (at group level only)
- Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels
- Lumpectomy, Partial Mastectomy, Simply Mastectomy
- Non-emergent Coronary Artery Bypass Graft (CABG)
- Renal or Ureteral Stone Surgical Treatment
- Medicare Spending Per Beneficiary Physician
- Total Per Capita Cost

We offer comments on two measures, Medicare Spending Per Beneficiary Clinician and Total Per Capita Cost.

<u>Medicare Spending Per Beneficiary Clinician (MSPB)</u>

Currently, the main cost measure that some emergency physicians are accountable for in MIPS is the Medicare spending per beneficiary (MSPB) clinician measure. The MSPB measure captures the “cost of services performed by hospitals and other healthcare providers during the period immediately prior to, during, and following a beneficiary's hospital stay.” It attributes all Medicare Part A and B costs occurring in the episode window to the clinician(s) responsible for care—which could end up indirectly being an emergency physician. In the past, ACEP has argued that this measure does not appropriately reflect costs of services that are controlled by emergency physicians, as emergency physicians are not the physicians who are driving the cost of care during a hospital stay. Many emergency physicians do not know how they are attributed to the measure and feel helpless to improve their performance. They also do not receive timely feedback on the measure. ACEP is pleased that CMS is proposing to incorporate an emergency medicine episode-based cost measure that was developed by Acumen into the MIPS program starting in performance year 2024. We hope with the addition of this measure, emergency

physicians will no longer be assessed based on the MSPB measure and will have more control over their performance in the Cost Category of MIPS.

Total Per Capita Cost

Per capita cost reflects the total amount billed per patient, not the costs of treatment by the individual provider. An emergency physician, for example, has no control over what another physician orders for that patient. Thus, this measure, which is ultimately attributed to the emergency physician, does not accurately represent the actual performance of the emergency physician. Again, we hope that the addition of emergency medicine episode-based cost measure will alleviate some of our overall concerns about the Cost Category of MIPS.

Thank you for the opportunity to share our comments. If you have any questions, please contact Erin Grossmann, ACEP's Regulatory and External Affairs Manager, at *[redacted]*.

Sincerely,

Christopher S. Kang, MD, FACEP

ACEP President

3.1.19 Comment Number 19

- **Date:** 7/21/2023
- **Submitter Name, Credentials, and Organization:** Sharon Grutman, American Society of Breast Surgeons
- **Comment Text:**

RE: MACRA Wave 2 Cost Measures: Call for Public Comment for Measure Reevaluation (2023)

To Whom it May Concern:

On behalf of the American Society of Breast Surgeons (ASBrS), we thank Acumen for the opportunity to participate in the reevaluation of episode-based cost measures currently in use under the Merit-Based Incentive Payment System (MIPS). ASBrS, the primary leadership organization for surgeons who treat patients with breast cancer and benign breast diseases, is committed to continually improving the practice of breast surgery by serving as an advocate for those who seek excellence in the care of breast patients. Founded in 1995, the Society now has more than 3,000 members throughout the United States and in 35 countries around the world.

Multiple ASBrS members served on the Wave 2 workgroup that developed the *Lumpectomy, Partial Mastectomy, Simple Mastectomy* episode-based cost measure, which was developed during Wave 2 of Acumen's Medicare and CHIP Reauthorization Act (MACRA) Cost Measure Project and is now one of 12 measures under consideration for comprehensive reevaluation. The *Lumpectomy, Partial Mastectomy, Simple Mastectomy* measure was later adopted for use under MIPS starting in 2020. However, due to the impact of the COVID-19 pandemic on patients, clinicians, and the services they provide, CMS decided to re-weight the MIPS cost performance

category for both the 2020 and 2021 performance periods. CMS acknowledged at the time that it could not reliably calculate scores for cost measures that would adequately capture and reflect the performance of MIPS eligible clinicians. The scoring of the *Lumpectomy, Partial Mastectomy, Simple Mastectomy* measure resumed in 2022, but CMS has not yet released aggregate MIPS participation data beyond the 2021 performance year.

The ASBrS appreciates that Acumen has developed a process for periodically reevaluating cost measures in use under MIPS. This process is important in terms of ensuring that a measure reflects the most current clinical evidence, as well as any coding updates that might have been adopted since the measure was first developed. It is also critical in terms of assessing the real-world impact of the measure and ensuring that it is capturing and measuring data as intended. However, we are concerned that due to the COVID-19 pandemic and CMS' decision to re-weight the cost category, there is very limited data on which to accurately assess the impact and appropriateness of the measures now under review. Even where data exists (e.g., the 2021 patient-level data supplemental performance feedback reports distributed to clinicians and group practices), it is not necessarily representative of normal times or standard performance trends. CMS also has not released any aggregate data or comprehensive analyses comparing, for example, implementation of these measures across different geographic locations, patient populations, and practice settings (e.g., private vs. academic).

In the absence of such data, the ASBrS cannot reasonably provide feedback on the implementation of the *Lumpectomy, Partial Mastectomy, Simple Mastectomy* measure. We strongly recommend that Acumen revisit its evaluation of all Wave 2 measures once more data are available, and the impact of the pandemic is no longer a concern. We also strongly urge Acumen to work with CMS to provide the public with comprehensive analytics regarding the real-world application of these cost measures so that stakeholders can better determine whether they are achieving their intended goals.

Finally, the ASBrS reminds Acumen of other concerns it has raised in the past that have not yet been resolved. For example, many physicians continue to face challenges accessing performance feedback reports, where they do exist, and those who are able to access reports are often unable to make sense of the data. Cost measures also continue to rely exclusively on administrative claims data, which does not provide a complete picture of patient care and limits the accuracy of critical measure components, such as risk stratification, subgrouping, and defining appropriate inclusion and exclusion criteria. Claims data are also easily impacted by coding practices. For example, practices that have the resources to code for every comorbidity will benefit from risk-adjustments and likely perform better on a cost measure compared to a practice with limited resources. Finally, we remind Acumen of the ongoing need to better account for quality when measuring cost. Currently, all of the cost measures developed for MIPS evaluate cost in isolation, without assessing the impact that cost reduction may have on patient outcomes.

The ASBrS appreciates the opportunity to weigh in during this reevaluation period and hopes that Acumen will work with CMS to address the concerns outlined in this letter. Should you have any questions or would like to schedule a meeting to discuss our concerns, please contact Sharon Grutman, Director, Advocacy, Communications, & Quality Initiatives at *[redacted]*.

Sincerely,

Susan K. Boolbol, MD, FACS
President

3.1.20 Comment Number 20

- **Date:** 7/21/2023
- **Submitter Name, Credentials, and Organization:** Kim Karr, American Occupational Therapy Association
- **Comment Text:**

Re: MACRA Cost Measures: Call for Public Comment for Measure Reevaluation (2023)

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 244,500 occupational therapists, occupational therapy assistants, and students of occupational therapy (OT). The science-driven, evidence-based practice of occupational therapy enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Occupational therapy services are reimbursed under the Medicare Physician Fee Schedule (MPFS) and are therefore affected by Medicare Part B payment policies under the Quality Payment Program (QPP). Occupational therapy services are included in the current Merit-based Incentive Payment System (MIPS). AOTA would like to thank MACRA for the opportunity to comment on cost measure reevaluation as lack of cost measures applicable to occupational therapy has significantly limited OT participation in the MIPS program. AOTA acknowledges and appreciates the time and resources Acumen has devoted to ensuring that clinical input, including feedback from occupational therapy practitioners and the patients they serve, is obtained in cost measure development.

More than 75% of people aged 65 and older have multiple chronic conditions resulting in disproportionately high healthcare spending[2]. Occupational therapy interventions can improve patient outcomes and reduce costs through enhancement of diagnosis knowledge, health behavior changes, and skills for managing chronic conditions and surgery recovery[3]. Occupational therapy practitioners use energy conservation strategies, relaxation techniques, training in adaptive strategies and exercise to improve symptoms of pain, fatigue, poor sleep, reduced mobility, and mental well-being, all of which have direct impact on timely recovery from illness and injury[4]. By facilitating care designed to identify and teach individuals adaptive strategies for health management that incorporate self- management principles and facilitate the development of coping strategies to support health and well-being, occupational therapy is able to reduce adverse

[2] Leland NE, Fogelberg DJ, Halle AD, Mroz TM. Occupational Therapy and Management of Multiple Chronic Conditions in the Context of Health Care Reform. Am J Occup Ther. 2017 Jan/Feb;71(1):7101090010p1-7101090010p6. doi: 10.5014/ajot.2017.711001. PMID: 28027031; PMCID: PMC5182013.
[3] https://www.aota.org/practice/practice-essentials/evidencebased-practiceknowledge-translation/critically-appraised-topic-selfmanagement-interventions-for-people-with-pulmonar-cardiac-or-kidney-conditions
[4] https://www.aota.org/publications/sis-quarterly/rehabilitation-disability-sis/rdsis-8-21

health events and improve patient outcomes which reduces overall cost of care for chronic conditions such as COPD, kidney disease, heart failure, depression, psychoses or low back pain, as well as post-surgical conditions like lumbar spine fusion, mastectomy, hip arthroplasty, and other surgeries.

Despite the value occupational therapy brings to cost management of care, cost measures currently under reevaluation exclude OT practitioners from reporting due to current coding and order prescribing requirements. To date, only one cost measure has been developed which includes occupational therapists as attributed clinicians, severely limiting OT engagement with MIPS and preventing engagement with MVPs which require an associated cost measure for participation. **We are appreciative of the development of the Low Back Pain cost measure which includes therapists as attributed clinicians; however, the focus of this measure does not encompass the wider scope of occupational therapy practice in the Medicare part B outpatient space which limits the range of OT practitioners who can engage with the measure**. Without associated cost measures that reflect the full scope of occupational therapy services, gaps in care recognition remain within the MIPS system.

In other cost measures, such as those under reevaluation, OT participation is limited to being a "downstream" service because the cost measures utilize exclusively Evaluation and Management (E/M) CPT codes as coding triggers. E/M codes are not billable by occupational therapists; therefore OT practitioners are unable to be considered an attributed clinician within the other available cost measures. **Inclusion of more cost measures that utilize E/M plus rehabilitation codes or rehabilitative codes alone would increase opportunities for OT engagement** in traditional MIPS, prepare the profession for participation in more MIPS Value Pathways (MVPs) which require an associated cost measure to participate, and encourage improved care coordination and patient outcomes.

AOTA encourages Acumen to continue thoughtful development of cost measures designed for therapy involvement so that therapy clinicians can more fully engage with the MIPS program and successful cost management through prudent use of occupational therapy services to reduce lengths of stay, prevent rehospitalizations, and improve patient independence can be encouraged and appropriately rewarded. We look forward to continued partnership with Acumen to facilitate high quality cost measures that accurately reflect patient care delivery.

Sincerely,

Kim Karr, OTR/L
Manager, Coding and Payment Policy

3.1.21 Comment Number 21

- **Date:** 7/21/2023
- **Submitter Name, Credentials, and Organization:** Don Good, InContext
- **Comment Text:**

RE: Comments on MIPS Cost Measure Specifications under contract number 75FCMC18D0015, Task Order 75FCMC19F0004

On behalf of InContext, LLC and the clients we represent, we appreciate the opportunity to offer our technical measure specification comments to Acumen and the Centers for Medicare & Medicaid (CMS) for several cost measures.

Our Firm (InContext) has dedicated years to ensuring that our clients continue to advance at the forefront of value-based care, including exceptional performance under the QPP and the preceding PQRS/VBM and Meaningful Use programs. We consult with a diverse range of provider types, including but not limited to: diagnostic radiology, interventional radiology, anesthesiology, pathology, large multi-specialty groups, and orthopaedic practices; health systems; and Accountable Care Organizations (ACO) and a number of the CMMI programs. We also have extensive experience supporting clients on a wide range of Commercial, Medicare Advantage and Self-Insured Employer value- based payment arrangements.

Our specialty-specific experiences with the QPP have provided us with a unique and consistent set of challenges, especially within the context of ancillary and specialty care, such as radiology, anesthesiology, pathology, and orthopaedics. To this end, we express our gratitude to CMS for its continued efforts to improve the applicability of the program and related cost measures for ancillary/specialty providers. We look forward to any and all opportunities to work with the Agency in improving the QPP for such providers in future years.

Outlined below are our comments on two of the MIPS Cost measures under review: The TPCC and MSBP Cost Measures. As requested, we have provided our suggested technical changes for each measure below.

1) **TPCC Measure**
   a) **Recommendation:** Physician Extenders (NP's/PA's) should be excluded or included based on a majority count of the included or excluded providers in the group/TIN (see code table accompanying the measure). In the case of a specialty practice, such as radiology, this would mean excluding the NP's/PA's. **Example if the recommendation was applied to a: In a** Radiology Practice with 90 Diagnostic and or Interventional Radiologists and 10 NP's billing under the TIN , the 10 NP's would be excluded from the TPCC measure as 100% of the non-Physician Extender Providers are excluded from the measure due to their specialty.
      i) **Rationale:**
         (1) **Section 2.2 of the measure states:** "After service category exclusions are applied, clinicians who would not reasonably be responsible for providing primary care are excluded from attribution of the TPCC measure."

         Current State: NP's and PA's that are part of Groups/TIN's that are surgical, or diagnostic in nature are attributed patients under this measure. Yet these TIN' and providers, other than billing E&M codes are **NOT** rendering primary care services, and therefore an Orthopaedic group for example that contains NP's and PA's should not be asked to set up

Primary Care Centric Care coordination, managing chronic conditions such as: Kidney disease, Diabetes, COPD, CAD, etc. Not only does attribution take place in these surgical or diagnostic groups, but when the measure is scored, they typically perform poorly as they are being held accountable for services and outcomes that are outside of their scope of Practice. Example: Interventional Radiology (IR) practice is attributed patients for TPCC when they use their PA/NP to see patients in a pre or post-operative outpatient clinic visit involving an IR procedure. This practice is being held to the overall health of this patient for a 12-month period, even though they are not this patient's primary care provider and are unlikely to see them once the IR procedure episode of care is complete. When specialty practices such as these trigger this measure they are unfairly compared to primary care practices.

2) **MSPB Measure**
   a) **Recommendation** - In the event an Eligible Clinician (EC) is eligible for one or more of the episode- based cost measures, we encourage CMS to exempt the EC from the Medicare Spend per Beneficiary (MSPB) Cost measure.
      i) **Rationale**: By retaining measurement under both the MSPB and the Episode-Based cost measures, the same patients are frequently measured twice (under each measure) for the same Episode. Since the MSPB measure is not specialty specific it makes sense to exempt the EC from this cost measure if one or more of the Episode-based cost measures apply.

   b) **Recommendation** - There are a number of Interventional Radiology CPTs that should be deleted from this measure, as an Interventional Radiology (IR) provider does not drive the episode of care. These are listed below.
      i) **Rationale:** Even though IR providers will provide the services listed below, another provider is controlling the episode of care for the patient (these include: gastroenterologist, breast surgeon, vascular surgery, etc) and are "ordering a service" from the IR Provider.
      ii) **Current State:** Inserting a feeding tube, drain, catheter etc , **should not drive attribution** to the Interventional Radiologist, but today it does. When reviewing the episodes of care where these CPT's are billed, it's extremely clear that the Interventional Radiologist is **NOT** driving the care plan in the Hospital, the Patient discharge decision/disposition, nor is the IR provider driving the post discharge care plan and follow-up. Unlike the ordering provider, the IR provider will rarely, if ever see the patient again for the episode as there's no clinical need.
      iii) The CPT's listed below should be excluded from attribution for this measure:

CPT/HCPCS	CPT/HCPCS Label
36558	Insertion of tunneled central venous tube for infusion (5 years or older)
36561	Insertion of central venous tube with port (5 years or older)
36571	Insertion of central venous tube with port for infusion (5 years or older)
36581	Replacement of tunneled central venous tube
36582	Replacement of tunneled central venous tube with port
36590	Removal of central venous tube with port or pump
47490	Insertion of tube into gallbladder using imaging guidance with review by radiologist
49324	Insertion of abdominal cavity tube using an endoscope
49405	Drainage of fluid collection by tube through skin using imaging guidance
49406	Drainage of fluid collection of abdominal cavity by tube using imaging guidance
49418	Insertion of abdominal tube using imaging guidance with review by radiologist
49421	Insertion of abdominal cavity tube for drainage or dialysis
49422	Removal of abdominal cavity tube
49440	Insertion of stomach tube using fluoroscopic guidance with contrast
49446	Conversion of stomach tube to stomach-to-small bowel tube using fluoroscopic guidance with contrast
50432	Placement of tube of kidney using imaging guidance with review by radiologist
50433	Placement of tube of kidney and urinary tube through new skin access using imaging guidance with review by radiologist
50434	Conversion of kidney tube to nephroureteral tube using imaging guidance and study of kidney and ureter with review by radiologist
50706	Balloon dilation treatment of stricture of ureter using imaging guidance with review by radiologist
19083	Biopsy of breast and placement of locating device using ultrasound, first growth
36011	Insertion of tube into vein, first order branch
36217	Insertion of tube into chest or arm artery, initial third order branch
36246	Insertion of tube into abdominal, pelvic, or leg artery, initial second order branch
36247	Insertion of tube into abdominal, pelvic, or leg artery, initial third order branch
36251	Insertion of tube into first order main and accessory arteries of kidney for imaging with review by radiologist
36252	Insertion of tube into first order main and accessory arteries of both kidneys for imaging with review by radiologist
36253	Insertion of tube into second or third order branches of arteries of kidney for imaging with review by radiologist
36901	Insertion of needle and/or tube into hemodialysis circuit with review by radiologist
36902	Insertion of needle and/or tube into hemodialysis circuit and balloon dilation of dialysis segment with review by radiologist
36903	Insertion of needle and/or tube into hemodialysis circuit and insertion of stent in dialysis segment with review by radiologist

3) <u>All Measures:</u>

a) **Recommendation:** For each new and existing MIPS cost measure, the measure steward (in this case CMS) should be **required** to:
   (1) Clearly define a set of data elements (Data Model) that will be reported back to any Eligible Clinician that triggers the measure. The data element "table" should be required as an appendix to the Cost measure specification, much like the "Code list" tables accompany the measures today,
   (2) Clearly define when (specific months during the performance year) data will be provided, including the Dates of Service that will be provided to the industry with each reporting set. This too should be a required part of the Cost measure specification,
   (3) Then, when it's time to review a Cost measure and seek public comments, in addition to asking for public comments on Measure Specifications, the scope of the periodic review should also request comments on the items referenced above: The data elements that will be provided back to the industry along with commitments for timeliness of reporting.

b) **Rationale:** We believe the largest "gap" in the Cost category of MIPS is not the construction of new measures or the revision of existing measures, but instead the lack of timely, useful information provided to the industry on the cost measure results. In general (within the context of both MVPs and traditional MIPS), **CMS must provide more timely and actionable cost data if they truly want to hold health care providers accountable for cost and prepare providers for APM's. In**

addition, providers should be provided with adequate cost data to validate that their Performance Year scoring is correct.

c) **Current State:** For many, Providers cost is now worth 30% of their MIPS score and underlying payment adjustment. Unfortunately, across the industry what we see/hear is, "I have no information to make constructive change in cost …. I can't even tie the csv/excel tables to how my score was constructed, how do I even know it's correct? We get much better information from our Commercial and Medicare Advantage VBP programs. What am I supposed to do?" In our historical proposed rule comments, we have strongly suggested that:

(1) CMS provide monthly data at the same level provided years ago under the Value Modifier program. We believe it's contrary to the overall program rules, and unfair and illogical to hold Providers accountable for understanding and optimizing cost with scant information provided eight months after the close of the performance period. There seems to be no recognition that this is a material gap in the Program overall, and as a result, it is never discussed or committed to in rule making. We believe this should be prioritized ahead of MVPs and creating additional Cost measures, where no useful information is available to support the measures and drive change.
(2) Our point here is very simple, what good is a well-constructed MIPS Cost Measure if there is no useful, timely information provided to the industry? Perhaps an appropriate analogy is: Students are participating in a well-designed class that counts for 30% of their degree. Eight months after the close of the Term, they receive a grade for this class. No information is provided throughout the term that gives them the opportunity to see how they are doing, adjust course, etc. In this example we're guessing the Professor would be fired. Our observation is that instead of driving change through: thoughtful, timely, actionable, useful information on Cost measure results, the current Cost category of the program is rapidly driving increasing levels of frustration.

Again, we thank you for extending this opportunity to provide comment on the MIPS Cost Measures. As always, we look forward to working with CMS in its efforts to improve value-based care in Medicare.

Sincerely,

InContext, LLC

3.1.22 Comment Number 22

- **Date:** 7/19/2023
- **Submitter Name, Credentials, and Organization:** Katie O. Orrico, American Association of Neurological Surgeons

- **Comment Text:**

Subject: MACRA Wave 2 Cost Measures: Call for Public Comment for Measure Reevaluation (2023)

To Whom it May Concern:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing more than 4,000 neurosurgeons in the United States, we are writing to provide feedback on the episode-based cost measure titled "Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels." The Lumbar Fusion cost measure was developed during Wave 2 of Acumen's Medicare and CHIP Reauthorization Act (MACRA) Cost Measure Project with input from members of the AANS and CNS. The measure was first adopted under the Merit-Based Incentive Payment System (MIPS) in 2020 and is now undergoing a comprehensive reevaluation by the Centers for Medicare & Medicaid Services (CMS).

While the AANS and CNS appreciate that Acumen has adopted a process for re-evaluating its cost measures over time, we are concerned that there is little data on which to evaluate the Lumbar Fusion measure's use under MIPS to date. This measure was first adopted under MIPS in 2020. However, CMS opted not to score cost measures under MIPS for the 2020 and 2021 performance years due to COVID-19-related disruptions. Although scoring of the cost category resumed in 2022, CMS has not released participation data beyond the 2021 performance year through its Quality Payment Program Public Use File. Thus, there are no concrete data to assess this measure's real-world application and appropriateness.

Overall, our members who participated in the Wave 2 workgroup that developed the Lumbar Fusion measure felt it was reasonably specified, particularly since it relies on subgrouping to distinguish between the number of levels treated. **However, we strongly urge the CMS and Acumen to conduct an additional evaluation of all Wave 2 measures once more data are available, and the impact of the pandemic has subsided**. Many patients delayed seeking care during the pandemic, which could have impacted disease severity and costs. Practices also faced considerable challenges related to staffing shortages and other disruptions to their normal operations, some of which persist today. These aberrations make the data from these performance years less generalizable and point to the need to revisit this exercise at a later date.

The AANS and CNS also remain concerned about foundational flaws in Acumen's episode-based cost measure development process that have not been addressed since our involvement in Wave 2 and continue to plague new measure development. These include:

- Exclusive reliance on administrative claims data, which limits the accuracy of risk stratification, subgrouping, and defining appropriate inclusion and exclusion criteria;
- Ongoing failure of these cost measures to directly account for the impact that cost reduction may have on patient outcomes or other measures of quality; and
- Inappropriately clumping heterogenous patient populations under the denominator of a single measure.

The AANS and CNS strongly encourage Acumen to work with clinical stakeholders to address these ongoing shortcomings and to provide the public with additional data in the near future on which to reevaluate the Wave 2 measures. In addition, we urge Acumen to

defer making any substantial changes to this measure until you can adequately evaluate real-world performance.

Thank you for considering our views and requests. In the meantime, please do not hesitate to contact us should you have any questions or need additional information.

Sincerely,

Anthony L. Asher, MD, President
American Association of Neurological Surgeons

Elad I. Levy, MD, President
Congress of Neurological Surgeons

Staff Contact:
Rachel Groman, MPH
Vice President, Clinical Affairs and Quality Improvement
Hart Health Strategies

3.1.23 Comment Number 23

- **Date:** 7/21/2023
- **Submitter Name, Credentials, and Organization:** Stephanie Jones, American Society of Clinical Oncology
- **Comment Text:**

ASCO has been in communication with the US Oncology Network and McKesson as they reviewed their member practices' 2022 MIPS Preliminary Results and identified concerns regarding measure specification and implementation. Upon review of their feedback (attached), we wish to express agreement with their findings and analysis, and support for their suggested solutions for these measures. In addition, we add the following brief comments based on our findings and positions.

Total Per Capita Cost Measure

The US Oncology Network and McKesson found that the specialty exclusion may not appropriately trigger in the Total Per Capita Cost (TPCC) measure, despite the frequency by which oncologists and their Advanced Practice Providers (APP) manage chemotherapy treatments. This is further complicated by the retrospective method of this exclusion, leaving oncologists unaware of whether they will be assessed by this measure. ASCO has previously supported a prospective, specialty-based exclusion for oncologists that is not reliant upon percentage of candidate events being comprised chemotherapy services. We have also brought up concerns regarding attribution to APPs and support exploration of the potential solutions offered by the US Oncology Network and McKesson.

Medicare Spending per Beneficiary

The US Oncology Network and McKesson raised concerns that the Medicare Spending per Beneficiary (MSPB) measure fails to adequately adjust for the resources necessary to delivery

cancer care, which has a negative impact on oncologists' MIPS scores. ASCO agrees that for patients with an existing acute or treatment-intense chronic condition will have substantially higher expenses in the 30 days after admission, often unrelated to the admission itself. It is often the case that an admission interrupts planned ambulatory care, which resumes after the admission and cannot be appropriately counted for in an inpatient/post-acute episode. We agree that the MSPB measure is not designed for these cases and support solutions that exclude either the episode, or the chemotherapy-related expenses, from the measure.

Chronic Condition Episode-Based Cost Measures – Diabetes and Asthma/COPD

The US Oncology Network and McKesson identified examples of oncologists having been attributed episode-based cost measures for Diabetes and Asthma/COPD, despite the oncologist not having medically assumed care for these conditions. It is important that oncologists document clinically significant complications of care that impact, and may alter, the course of chemotherapy and oncology treatments. Episode-based cost measures, such as diabetes and asthma are intended to apply to primary care physicians and specialists who are actively managing these conditions, not to specialists to whom these conditions are a complication of care. We do not want to see a situation whereby
oncologists fail to appropriately document diagnoses, in fear that they will be misattributed one of these episodes. We also remind CMS that in specialty models, such as the Enhancing Oncology Model, restricts attribution to certain TINs to prevent misattribution to other specialties.

We continue our commitment to work with CMS to improve measures and the MIPS Value Pathways. We hope that you will find our comments to be informative as you work towards the same goal.

Respectfully submitted.

3.1.24 Comment Number 24

- **Date:** 7/19/2023
- **Submitter Name, Credentials, and Organization:** Erin Crum, US Oncology Network and McKesson
- **Comment Text (this feedback is also attached Comment Number 8):**

MIPS Cost Measure Feedback
Reviewing the 2022 MIPS Preliminary Results, the US Oncology Network and McKesson are concerned by several cost measures and the impact to medical oncology clinician and practice performance. Upon thorough review of the measure specifications, we want to highlight for CMS several areas of concern where the attribution and measure methodology may not function as intended; ultimately, this has an unfair, negative impact for medical oncologists and their care teams' ability to achieve high performance for cost measures that are intended to reflect quality,

cost-effective care. Below is a summary of our findings, along with recommendations to rectify scoring for the 2022 MIPS performance year and future program years for the following four cost measures:

1) Total Per Capita Cost Measure (TPCC)
2) Medicare Spending Per Beneficiary (MSPB)
3) Chronic Conditions: Diabetes
4) Asthma and Chronic Obstructive Pulmonary Disease

Total Per Capita Cost Measure (TPCC)

The Total Per Capita Cost measure assesses the overall cost of care delivered to a patient with a focus on the primary care they receive from their clinicians. This is the only cost measure currently included in the Advancing Cancer Care MVP. Effective primary care management can help reduce overall healthcare expenditures and the intent of the measure is to assess clinicians who have an established primary care relationship with the patient. Certain specialty clinicians are automatically excluded based on their Health Care Finance Administration (HCFA) Specialty designation (such as radiation oncologists, dermatologists, and pathologists), as they are unlikely to provide primary care services.

In order to ensure a focus on primary care, additional clinicians are excluded from attribution if they meet the criteria for one or more service exclusions in the following categories: global surgery, anesthesia, therapeutic radiation, and chemotherapy. Although this methodology intends to exclude clinicians who are providing specialty-specific care, it does not function as expected in actual clinical care settings. Specifically, medical oncology care teams are inappropriately attributed patients who are on active chemotherapy or surveillance.

TPCC Flawed Attribution Logic Negatively Impacts Medical Oncology Practices

Clinicians are excluded from attribution if 10% or more of the clinician's candidate events are comprised of chemotherapy services. However, APPs (NPs and CNSs) are likely to have patients on active chemotherapy attributed to them, where they do not bill chemotherapy under their NPI. This could result in a group-level score or individual APP score, if MIPS-eligibility and case minimums are met. It is likely that many APPs will be attributed patients that were receiving chemotherapy since it is prescribed by the attending clinician; these events should have been excluded.

In addition to this, many of the "primary care services" that are referenced as part of the trigger for a candidate event may, in fact, be related to cancer care and not primary care. For example,

- A variety of blood tests are included in the list of primary care service codes that may trigger a candidate event indicating a primary care relationship with a clinician. However, these tests may be routinely ordered to monitor a patient's response or tolerance to certain chemotherapy regimens.
    - An example of routine labs ordered by oncology clinicians for cancer patients on active chemotherapy may include: [85004] white blood cell count (WBC); [85007-85008] WBC with manual count; [85013-85014] red blood cell (RBC) concentration or measurement; [85018] hemoglobin (HGB) blood count; [85025-85027] complete blood count (CBC) with or without differential; [85032] manual blood cell count; [85048] automated WBC count; [85049] platelet count; [80053]

comprehensive metabolic panel (CMP), and many other pertinent labs for monitoring of chemo-induced or related symptoms of cancer such as anemia, fatigue, risk of infection, dehydration and more.

- Ketone analysis [CPT 82009 or 82010] is one of the primary care service codes that may trigger a candidate event indicating a primary care relationship with a clinician. However, clinicians may order ketone analysis for patients who are diabetic and require steroids during chemo treatment and/or patients who are actively undergoing treatment with a regimen that includes nephrotoxic medication(s).

Many x-rays, procedures, and labs indicative of primary care are often included as part of routine cancer care management for patients on chemotherapy or active surveillance. These services would be unrelated to primary care and inaccurately trigger a candidate event based on the current TPCC methodology.

Lastly, although chemotherapy services include oral and hormonal antineoplastics, the TPCC measure exclusion criteria do not consider oral drugs covered under Part D on the list of trigger codes to indicate receipt of chemotherapy. 40% of anti-cancer treatment today is provided with oral anti-neoplastic agents, and hormonal anti-neoplastic drugs. The measure only references chemotherapy administration codes (billed to Medicare Part B) to assess whether the patient is receiving chemotherapy services. Oral chemotherapy prescriptions candidate events that should be considered when assessing whether a clinician has more than 10% of events tied to chemotherapy treatment that would exclude the clinician from attribution.

Possible Solutions to Correct the TPCC Attribution Methodology

Centers for Medicare & Medicaid Services (CMS) and its contractor, Acumen, LLC, specifically asked for feedback concerning the TPCC measure attribution and methods to establish a primary care relationship. The US Oncology Network and McKesson believe that immediate action must be taken regarding the current 2022 MIPS Preliminary Results to avoid unfairly scoring medical oncologists and their extended APP care teams. In addition to this, we recommend modifying the attribution logic going forward for future MIPS program years so that only clinicians responsible for primary care are assessed for the measure.

To correct the current 2022 MIPS Preliminary Results, as well as to modify the measure methodology for future MIPS program years, below are several approaches for CMS and Acumen's consideration:

- Exclude Oncology as an eligible specialty for the measure using the HCFA designation (as the exclusion for providing chemotherapy services can be effectively accomplished by excluding Oncology specialists, similar to how radiation oncologists or surgeons are excluded for the provision of radiation or surgical services).
- Exclude APPs who may have attributed patients based on reporting TIN (i.e., exclude APPs in a TIN with a plurality of clinicians who are excluded specialists; APPs may lack a specialty designation, but should be considered under oncology based on their affiliated clinicians within the TIN).

- Consider excluding PATIENTS who are on active chemotherapy from attribution during chemotherapy episodes of care; assume that patients under active chemotherapy will have care focused on the treatment of their cancer, which may confound measure performance which is intended to assess cost of primary care services. Ensure that all infused and oral chemotherapy agents (Medicare Part B and Part D) are considered when assessing whether a clinician has more than 10% of candidate events tied to chemotherapy treatment that would exclude the clinician from attribution.

Medicare Spending Per Beneficiary Measure (MSPB)

The MSPB Clinician measure assesses the cost to Medicare for services provided to a patient during an MSPB Clinician episode, which comprises the period immediately prior to, during, and following the patient's hospital stay. An episode includes Medicare Part A and Part B claims with a start date between 3 days prior to a hospital admission through 30 days after hospital discharge, excluding a defined list of services that are unlikely to be influenced by the clinician's care decisions and are, thus, considered unrelated to the episode.

MSPB Methodology Inflates Costs for Medical Oncology Practices

Although the measure is risk-adjusted to assess comorbidities, patient age, and other pre-existing patient characteristics, the measure does not accurately adjust for or exclude patients who are on active chemotherapy treatment which would have a significant impact on the episode cost. This measure includes Medicare Part B drugs as part of the total cost determination during the 3-day pre-admission, and 30-day post admission periods. Patients who are on active treatment may have chemotherapy drugs included in the episode cost determination. In addition, active chemotherapy does NOT include Part D drugs, introducing additional variability between patients. Ultimately, medical oncologists and their care teams may be associated with a larger proportion of patients with MSPM episodes where patients are on active chemotherapy (Medicare Part B drugs) within the episode period.

Possible Solutions to Correct the MSPB Methodology

The US Oncology Network and McKesson believe that immediate action must be taken regarding the current 2022 MIPS Preliminary Results to avoid variable and unfair MSPB cost measure scoring across specialties. In addition to this, we recommend modifying the methodology going forward. To correct the current 2022 MIPS Preliminary Results, as well as to modify the measure methodology for future MIPS program years, below recommendations for CMS and Acumen's consideration:

- Exclude all Medicare Part B drug costs associated with chemotherapy treatment to remove variability of costs associated with different chemotherapy regimens (i.e. Medicare Part D drugs are currently omitted from cost calculations, where Part B are included)
- Consider specialty-specific benchmarking and scoring for the MSPB measure. This would enable more accurate, fair comparisons within specialties that provide similar care and should be expected to accrue comparable costs for a risk-adjusted patient population.

Chronic Condition Episode-Based Cost Measures – Diabetes and Asthma/COPD
The two Chronic Conditions episode-based cost measures evaluate a clinician's or clinician group's risk-adjusted cost to Medicare for patients receiving medical care to manage and treat diabetes and asthma/COPD. These chronic condition measures are intended to include the costs of services that are clinically related to the attributed clinician's role in managing care for these chronic conditions during an episode.

We understand that attribution is based on identifying a clinician-patient care relationship based on services billed and diagnosis information found on the claim. There are two different sets of CPT/HCPCS codes used to identify a trigger event: E&M codes for outpatient services, and condition-related CPT/HCPCS codes. To identify a trigger event, the following two claims must be billed within 180 days of one another: a trigger claim (an outpatient services E&M code with a relevant chronic condition diagnosis) and a confirming claim (either (i) another outpatient services E&M code with a relevant chronic condition diagnosis or (ii) a condition-related CPT/HCPCS code with a relevant chronic condition diagnosis). Both claims must have a diagnosis code for the relevant chronic condition.

Chronic Condition Measures Flawed Methodology Negatively Impacts Medical Oncology Practices

The current methodology specifies that patients with claims that include HCC coding for diabetes and Asthma/COPD may trigger attribution for clinicians. If a practice or clinician participates in Chronic Conditions Management (CCM), the expectation is that they are managing chronic conditions for their patients, and therefore, it would be appropriate to have these patients attributed to the clinician and/or practice. However, many US Oncology Network clinicians include HCC codes in their medical record documentation, as well as medical billing, to indicate that the chronic condition factored into cancer treatment and management decisions – and not related to the care of the chronic condition. When an HCC code is added to a claim as a secondary diagnosis, it cannot be assumed that the clinician is managing those conditions when the patient is being cared for by a specialist for a primary diagnosis in his or her area of expertise.

In addition to this, billing certain procedure codes may be considered as part of the trigger and confirming claims; however, there may be justification for these that are unrelated to the management of chronic conditions. For example, the list of measure trigger codes include:

- Services that may be ordered by any specialist (including oncologists for the routine care of cancer patients) – ex: office visits, blood glucose test, chest X-ray, etc.
- Services provided to cancer patients for management of associated conditions – ex: nutritional assessments done by dieticians for cancer patients are billed the same as nutritional assessments done for diabetes patients.
- Drugs that may be provided to patients for the care of other conditions in addition to the condition for the episode eligibility – ex: albuterol, budesonide, beclomethasone used for

asthma/COPD patients may be used for immune related conditions, post-transplant settings, etc.

- Biological drugs that are administered by practices for the care of non-oncology conditions – ex: omalizumab. This scenario may be encountered with drugs administered for neurological, dermatological, rheumatological, immunological and other conditions.
- Codes indicating chronic, principal, or transitional care management for patients with multiple chronic conditions.

See the specific examples below where triggering procedure codes are not related to the treatment or management of chronic conditions:

1. **Chronic Condition: Diabetes**
   Triggering event where the procedure may not be associated with diabetic treatment or management, when ordered for oncology patients on active chemotherapy:
   - Ketone analysis [CPT 82009 or 82010] may trigger attribution for the diabetes cost measure. Clinicians may order ketone analysis for patients who are:
     - Diabetic and require steroids during chemo treatment and/or;
     - Patient is actively undergoing treatment with a regimen that includes nephrotoxic medication(s).
   - Urine microalbumin [CPT 82043 or 82044] may trigger attribution for the diabetes cost measure. Clinicians may order this test for cancer patients undergoing treatment, to monitor for potential risks to kidney function or who have documented diminished renal capacity.
   - Medical nutrition [CPT 97802, 97803 or 97804] may trigger attribution for the diabetes cost measure. Therapy is often billed by dieticians for patients with cancer who need additional support due to chemotherapy side effects, toxicity, or excessive weight loss. Any of these codes may be noted when oncology clinicians order or provide nutritional counseling for cancer patients that may also have diabetes as a secondary condition.
2. **Chronic Condition: Asthma/COPD**
   Triggering event where the procedure may not be associated with Asthma/COPD treatment or management, when ordered for oncology patients on active chemotherapy:
   - alpha-1 antitrypsin [CPT 82103] may trigger attribution for the asthma/COPD cost measure. Clinicians may order this lab test for a number of reasons, to include circumstances where jaundice, other inflammatory processes, or tumor progression may be in question.
   - PFT [CPT 94060 or 94070] may trigger attribution for the asthma/COPD cost measure. Clinicians may order this procedure to assess baseline pulmonary functions prior to treatment and/or to assess for pulmonary toxicities during or post chemotherapy.

Possible Solutions to Correct the Chronic Condition Measures Attribution Methodology

To summarize, the combination of HCCs + E/M or procedure codes that trigger attribution for the chronic condition measures do not account for oncology-specific use cases. Instead, these same tests or procedures are ordered in relation to cancer care/treatment and not the management of chronic diseases.

To correct the current 2022 MIPS Preliminary Results, as well as to modify the measure methodology for future MIPS program years, below are several approaches for CMS and Acumen's consideration:

- Exclude Oncology as an eligible specialty for non-oncology episode-based measures using the HCFA designation.
- Considering the above scenarios, a single attribution methodology that accounts for the nuances of all the above conditions may not exist for specialty clinicians. Consider referencing the Chronic Conditions Management codes as a trigger to attribute patients to non-primary care clinicians (i.e., specialists, such as oncologists).
- Consider excluding trigger events for episode-based measures when a primary cancer diagnosis is present on the patient's claim.

3.1.25 Comment Number 25

- **Date:** 7/20/2023
- **Submitter Name, Credentials, and Organization:** Matthew James Twetten, International Society for the Advancement of Spine Surgery
- **Comment Text:**

July 20, 2023
Re: MACRA Cost Measures Comment Perio
Submitted Online

To Whom It May Concern:

The International Society for the Advancement of Spine Surgery (ISASS) is pleased to have the opportunity to offer comments to the Centers for Medicare & Medicaid Services (CMS) on the development of the Wave-2 episode-based cost measures for Lumbar Spine Fusion for Degenerative Disease, 1-3 levels.

ISASS strongly supports initiatives that aim to promote and enhance quality of care and patient outcomes. In line with this, we have generally supported the episode-based cost measures for Lumbar Spine Fusion. However, there are several areas of concern we wish to highlight.

While the ISASS recognizes the effort that the CMS has put into establishing the Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels episode group metric, we have several critical concerns regarding its methodology.

Our primary concern is that many things which are outside physician control are included in this measure. For example, a SNF stay after lumbar spine surgery is often more the result of patient factors rather than surgeon factors. Including this in the cost calculation would unfairly penalize surgeons which take on more high-risk patients. This is similarly relevant to including pain management in the episode of care. By penalizing surgeons who utilize these services, it would decrease access to care to the most vulnerable patients who need this most.

The risk adjustment process is fundamentally flawed. The HCC categories do not adequately adjust for unmeasurable patient factors which go into spine surgery. While inclusion of factors such as obesity, smoking, rheumatoid disease, anticoagulant use and osteoporosis are essential, this neglects to include factors such as psychological illness, depression, chronic pain. Furthermore, many unmeasurable factors are not accounted for, such as a patient's degree of somatization, psychosocial support network and potential secondary gain.

The risk adjustment also does not adequately account for socioeconomic factors. The current model relies heavily on medical history and clinical variables while overlooking crucial socioeconomic determinants of health. These determinants, such as income, education, and living conditions, can significantly affect patient outcomes and must be considered to ensure a fair and holistic evaluation of the episode costs. Our research team has shown that inclusion of neighborhood socioeconomic factors can improve on HCC's outcome prediction models.1

Failure to properly risk adjust runs the risk of adverse selection. Physicians who have more challenging patient populations, especially from a socioeconomic lens, will be unfairly penalized. This is a known issue with quality metrics2 and would be exacerbated with a pathology that has highly subjective outcomes (patient pain) like lumbar degenerative disease.

Furthermore, the existing model creates an opportunity for upcoding to manipulate the risk adjustment. By encouraging providers to code more severe diagnoses, the model can inadvertently reward the appearance of improved outcomes rather than actual improvements in patient care. This distortion may undermine the genuine intent of improving patient outcomes and misrepresents the quality of care provided. This is, again, a problem with CMS's quality metrics that has been reported in the literature.3
In light of the above issues, the ISASS urges the CMS to reconsider the methodological aspects of this model. We look forward to continued collaboration with CMS to optimize these models for better patient care and more accurate cost assessments.

Thank you for considering this request and we look forward to collaborating to improve the quality measure process for providers and patients. If you need any additional information or wish to discuss this request, please contact me at *[redacted]*.

Sincerely,
Mogan Lorio, MD
ISASS Coding and Reimbursement Task Force Chair

References
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3. Silva GC, Jiang L, Gutman R, et al. Mortality Trends for Veterans Hospitalized With Heart Failure and Pneumonia Using Claims-Based vs Clinical Risk-Adjustment Variables. JAMA internal medicine. Mar 1 2020;180(3):347-355. doi:10.1001/jamainternmed.2019.5970

3.1.26 Comment Number 26

- **Date:** 7/21/2023
- **Submitter Name, Credentials, and Organization:** Fareen Pourhamidi, American College of Cardiology
- **Comment Text:**

DATE: July 21st, 2023
TO: Acumen LLC
FROM: American College of Cardiology
SUBJECT: 2023 “Wave 2” Cost Measures Reevaluation Comment Period

Thank you for the opportunity to provide feedback on measures from “Wave 2” of CMS and Acumen’s comprehensive reevaluation comment period. The American College of Cardiology recognizes the importance of cost assessment in pay-for-performance programs and is pleased to comment on the Medicare Spending per Beneficiary (MSPB, CBE #3574) Clinician and Total Per Capita Cost (TPCC, CBE #3575) measures.

Obtaining thorough and comprehensive feedback from members of the specialty remains somewhat challenging due to the limited availability of timely feedback, clinician access to data, and the impact of the COVID-19 pandemic on data submission from clinicians and facilities. However, we do offer our thoughts on the two cost measures, below.

Medicare Spending Per Beneficiary Clinician Measure

During the July 2020 committee deliberations of the National Quality Forum's Cost and Resource Use Committee, several major concerns with the MSPB-Clinician measure were raised. These included the ability to attribute a care episode to multiple clinicians and clinician groups; low reliability in testing for individual clinicians; the lack of adjustment for social risk factors; the questionable ability to predict downstream costs after a hospitalization; and whether the measure is useful or meaningful to beneficiaries in terms of distinguishing clinician performance. While Acumen did address the concerns outlined by the committee, we believe

caution should be exercised in the utilization of this measure and the fact that the measure failed to receive endorsement from the consensus-based entity.

Attribution at the individual clinician level remains technically challenging, despite improvements to the attribution methodology. Often, clinicians are unaware of facility-level efforts to improve, especially if it pertains to "one-off" shared patients and when there is no routine sharing of responsibility for patient costs. Attribution to multiple clinicians/clinician groups, especially on a retrospective basis, leaves little information as to how to better coordinate care to improve efficient use of resources or costs. This must be done at the hospital or facility-level and trickle down to the clinicians, as many clinicians are not involved in performance measure activity, which may typically fall onto administrative staff. This lack of specificity is an impediment to helping clinicians/TINs quickly identify where the key areas are that drive overall differences in spending, which ultimately will improve QI efforts. As such, the burden is then on the provider to investigate and analyze the information received. We believe that reports should be provided which contain actionable data aimed at improving patient care and related costs.

Attribution for surgical procedures seem to follow a different set of rules: A few select surgical MS-DRGs are attributed using the 30% E&M rule, rather than a main procedure. During these surgical DRGs, the clinician(s) caring for the main disease process typically drive the care for the patient as opposed to the proceduralist who performed the primary procedure. Assignment at the group level is more desirable rather than on an individual clinician, and it has been shown that quality is not always tied to better care from an individual clinician. Early-career clinicians may also inadvertently take on sicker patients, or utilize more services, tests, etc., thus driving up costs. Assignment at the TIN or sub-TIN level versus utilizing NPI seems more appropriate.

Accountability at the clinician or small group level on this measure may lead to undesired effects of clinicians avoiding patients with social risk factors. There is a great deal of variation across practices (TINs) and individual physicians in the extent to which they care for people with social risk factors. While it may not have much of an impact on average, it is at the tails of the distribution where the effects are more apparent. Risk adjustment does not change the scores for most providers in most cases, but it does have an impact for those with large fractions of patients with social risk factors. Clinicians typically do not have control over their TIN assignments and they are generally used for financial and billing purposes and not intended for quality improvement programs.

Participation in a Virtual Group may be one solution to the cost category conundrum for specialists. Virtual groups are typically a combination of two or more Taxpayer Identification Numbers (TINs) that choose to form a virtual group for the performance year, with no limit on the number of TINs. Individuals, groups of less than 10, or a combination of both can be utilized. This approach may make it more beneficial in creating more reasonable attribution for drivable costs and quality measures.

The measure broadly follows CMS' Hierarchical Condition Category (HCC) risk adjustment model, which is not sensitive to social risk factors as that data is not typically available from claims. It appears that gender and dual-eligibility status are utilized as SES proxies. At the time of testing, the risk adjustment model showed R-squared results ranging from 0.09 to 0.64 across the different groupings of providers. We would suggest consideration of the use of the Area Deprivation Index (ADI), which is readily available in terms of publicly reported data and is more robust in providing a better sense of the true social needs of patients.

Finally, we suggest incorporating the patient perspective in the measure, if appropriate and feasible, though this would likely require data beyond claims. Advanced-analytics models that predict patient readmission risk and guide intervention strategies are another critical technology opportunity that may supplant the prior suggestion, however. Associated quality measures could include assessments such as PROMs and discharge/post-discharge patient engagement at the facility level. The first few days of discharge provide a critical opportunity for care coordinators to engage with patients on activities including scheduling PCP or specialist follow-up visits, ensuring adherence to taking medications, identifying discharge destination preferences, and addressing potential barriers to healthcare access.

Total Per Capita Cost (TPCC) Measure

NQF's Cost & Efficiency Committee also expressed validity concerns over the TPCC Measure. The correlation with risk- and specialty-adjusted costs were considered low to moderate, and there continues to be a lack of social factors in the risk-adjustment model. While it was reported that inclusion of social factors in the model did not significantly change TIN or TIN-NPI performance scores on average, Acumen/CMS should still consider revising the risk-adjustment model to include social factors that are likely to influence the clinical health status of the population under consideration. Use of the ADI, as with the MSPB, may be useful.

The College appreciates the measure developer's continued refinement of the complex attribution methodology and the intent to improve care coordination among providers. The concern remains that a larger than ideal number of clinicians may erroneously be attributed costs over which they have no control. Particularly for specialist clinicians, this measure may be suboptimal for helping to drive meaningful improvements in care efficiency, as multiple clinicians can be attributed to the measure unrelated to practicing team-based care. We do not believe clinicians should be held responsible for costs that occurred long after they saw the patient and potentially after the patient has moved to another city or state. Also, we do not support attribution of the same costs to multiple clinicians in different practices when there is no evidence that they are practicing as a team.

Cardiologists in this measure, however, will be targeted as responsible for the costs of non-primary-care services that they do not provide and cannot control. For example, cardiologists are not conducting preventive services or procedures, such as colonoscopies, breast biopsies, or screening mammograms. We agree with the HCFA exclusions of interventional and surgical cardiology and cardiac EP, for example, but the inclusion of the entirety of cardiology as a specialty remains questionable. If cardiology must be included, we believe that only certain conditions such as heart failure, coronary artery disease, refractory hypertension, cardiac arrhythmias, and congenital heart disease be included for accountability in this measure. Yet, these may only apply to certain subset of clinicians within the specialty. We do wish to stress that overall we remain apprehensive of the inclusion of cardiology in this measure and that it may erroneously or unfairly attribute primary care costs to the wrong clinician type.

Finally, the measure relies on retrospective claims data, which may take months or even years to become available. This time lag limits the measure's ability to provide timely feedback to healthcare providers and stakeholders, hindering their ability to identify and address cost drivers promptly. Real-time or near-real-time data would be more useful for proactive interventions and cost management strategies.

In response to the more targeted questions from the survey, we offer the following responses:

Question 4. *The measure currently uses exclusions based on both services and HCFA Specialty to ensure that the measure only captures clinicians who provide primary care or care across multiple conditions. The advantage of service category exclusions is that it focuses on the care actually provided by clinicians, since HCFA Specialty lacks granularity for subspecialties who may provide different types of care. The disadvantages that these definitions are more complex than HCFA Specialty exclusions. Should the measure use only one type of exclusion rule to simplify the specifications? If so, which exclusion method should be used and why?*

By utilizing both service categories and HCFA specialties, a more detailed and nuanced understanding of cost patterns can emerge. Service categories provide a macro-level view of cost distribution across various types of healthcare services, while HCFA specialties offer a more granular assessment by focusing on specific provider specialties. This combination allows for a comprehensive evaluation of cost drivers and facilitates targeted interventions to address areas of concern.

It's worth noting that the choice between service categories and HCFA specialties may depend on the specific objectives of the analysis, the available data, and the healthcare context under consideration. Different stakeholders may have different priorities, and the choice of approach should align with the intended purpose of the analysis.

Question 5. *If the measure continues to use both service category and HCFA Specialty exclusions, what changes (if any) should be made to ensure that the measure is appropriately capturing clinicians who provide primary care type services?*

It’s not entirely clear other than through the HCFA Specialty list of inclusions as to why Cardiology is included. It appears that there are very few cardiovascular-specific services in the service list (other than ECGs, labs) that would apply as cardiovascular services.

Question 6. *The trigger rule methodology uses outpatient evaluation and management (E&M) codes to identify a clinician-patient relationship. There are many types of clinicians who do not bill E&M codes, such as physical therapists, occupational therapists, speech language pathologists, clinical psychologists, licensed clinical social workers, etc. This means that these specialties are effectively excluded from the measure. Should the trigger methodology be expanded to include clinicians who do not bill E&M codes? If so, what services do these specialties provide that should be added to the trigger methodology to identify a primary care or similar relationship?*

While some clinicians who do not bill E&M codes may provide important aspects of patient care, their roles are often more specialized and focused on specific procedures, diagnostics, or therapeutic interventions. It's worth noting that there can be some overlap or exceptions, as certain clinicians may have dual roles or provide both primary care and specialized services. For example, some pediatricians may perform minor surgical procedures or provide specialized care within their scope of practice. It may be worth investigating if additional clinicians should be included in the measure, however, it may add to the measure complexity and introduce the inclusion of other clinician-types with questionable attribution into the calculation.

Thank you for the opportunity to provide feedback in response to the comprehensive reevaluation of these measures. If you have any questions, please contact Ms. Fareen Pourhamidi at *[redacted]*

3.1.27 Comment Number 27

- **Date:** 7/20/2023
- **Submitter Name, Credentials, and Organization:** Jennifer Hananoki, American Medical Association
- **Comment Text:**

CMS and Acumen, LLC 2023 Cost Measures Reevaluation
AMA Comments
July 21, 2023
Submitted via online survey

Remove the Total Per Capita Cost and Medicare Spending Per Beneficiary Clinician Measures

The American Medical Association (AMA) strongly urges the Centers for Medicare & Medicaid Services (CMS) to remove the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) clinician measures from the Merit-based Incentive Payment System (MIPS). Measures should only cover costs that physicians can reasonably control. Neither the TPCC nor MSPB clinician measure can meet that criterion because the measures hold physicians accountable for patients' medical conditions that are managed outside of their organization and for costs they cannot influence such as drug prices. If CMS does not remove TPCC and MSPB clinician measures, CMS must address the attribution, exclusions, and double counting concerns raised in the following sections.

Relevance

In the 2020 Medicare Physician Fee Schedule (MPFS) proposed and final rules, CMS considered removing the TPCC measure from the program and not replacing it with the revised version. However, CMS decided against removal and explained its decision as follows: "we developed and implemented only a handful of episode-based measures at this time, [so] a substantial proportion of clinicians would be left with only the MSPB clinician measure for the cost performance category. Because fewer than half of all clinicians in MIPS meet the case minimum for the MSPB clinician measure, and no other measure addresses the costs of primary care, we stated that we believe it is appropriate to use the best version of the total per capita cost measure available to us."

The AMA strongly urges CMS to revisit whether TPCC is necessary, and we strongly believe that it is not based on CMS' own rationale from 2020 rulemaking. Unlike in 2020, there are now 23 episode-based MIPS cost measures currently in use and many more in the development pipeline. Many of these measures address the costs of primary care. In fact, in the Chronic Condition Episode-Based Cost Measures Attribution Methodology FAQ document, CMS provides the top five specialties for each of the 10 chronic condition episode-based cost measures developed to date. Of the 10 measures, internal medicine is in the top five for all. In addition, family practice is in the top five for seven of the 10 measures. Further, including the Wave 4 episode-based cost measures, which CMS is proposing to include in MIPS in the 2024

MPFS proposed rule, episode-based cost measures now account for 36.8 percent of all Medicare Parts A and B spending.

Furthermore, we believe it is inappropriate to put measuring the largest number of physicians in the Cost Performance Category above getting the measures and methodology right. We are pursuing legislative refinements to the Medicare Access and CHIP Reauthorization Act (MACRA) that would give CMS more flexibility to develop and use cost measures without an arbitrary target of Medicare Part A and Part B expenditures and to score cross-category measures. We hope the agency will work with the AMA and Congress to seek this authority so CMS can prioritize actionable measures with a demonstrated need for improvement and that measure cost within the context of quality.

Revised TPCC Attribution Methodology

The revised TPCC eliminates the problem of attributing costs that occurred before the physician ever saw the patient; the AMA agrees that physicians should not be held responsible for such services. However, we have concerns about other aspects of the new attribution approach. The revised attribution methodology assumes that a primary care relationship exists if two things happen within three days or three months, and not otherwise. This will lead to new problems as identified in the following examples:

- If a patient is getting cataract surgery or knee surgery, the surgery center will generally require the patient to be cleared for surgery by a primary care physician. The patient will find a primary care physician to examine them, the physician will likely order an electrocardiogram (EKG), and under the new TPCC measure, it appears that the physician will be accountable for everything that happens to the patient over the next 12 months, including the cataract surgery or knee surgery that was the only reason they came to see the physician in the first place. The revised measure could cause primary care physicians to refuse to do pre-surgical clearance visits on new patients in order to avoiding having the surgery patients appear on his or her attribution list.
- If a new patient comes to see a primary care physician, and the patient has multiple chronic conditions or health problems, the revised measure will give the physician an undesirable disincentive to schedule follow up visits within three months so the patient and their costs are not attributed to the physician.
- On the other hand, new patients who are healthy or whose health problems are appropriately managed and who do not need to come back to see the primary care physician for six months or one year would not be attributed to that physician. The low costs would not be reflected in the primary care physician's TPCC average, making it appear higher than reality. In that case, the primary care physician would need to order an EKG or other test simply to trigger attribution.

Another significant problem with the revised methodology is that it does not identify the end of a clinician's primary care responsibility for a patient. TPCC assigns responsibility for all Medicare Part A and B costs for 12 months after attribution. However, because CMS is aware that Medicare beneficiaries switch physicians or move to new states, the revised measure adopted a workaround that attributes the same patients and overlapping costs to multiple clinicians in different practices if they meet the attribution criteria. To illustrate the problems with this

change, under the previous measure, when a patient switches to a new primary care physician, the patient's new doctor may be held responsible for things that happened before he or she took over, but once the patient starts seeing a different doctor, the patient will be attributed to the new doctor. Under the revised measure, both physicians will be held responsible for services and procedures that happen after the patient switches to another physician. In another example, a beneficiary travels to a different city, experiences a health problem and visits a new primary care physician, who runs a laboratory test and determines the beneficiary is fine. The new physician is now responsible for all spending for this beneficiary for the next year, even though the beneficiary does not even live in the community.

The AMA does not believe physicians should be held responsible for costs that occurred long after they saw the patient and potentially after the patient has moved to another city or state. Also, we do not support attribution of the same costs to multiple physicians in different practices when there is no evidence that they are practicing as a team. We have concerns about the impact of spreading accountability so widely, which CMS believes will improve care coordination. Yet this assumes data regarding services provided by other physicians is readily available and therefore actionable by the attributed physician. CMS does not provide this information, and it would be next to impossible to track patients and make value-enhancing changes in their care because the revised attribution methodology relies on a lengthy list of services, including services provided by a separate physician practice. If CMS continues using a TPCC measure, the attribution methodology should be changed to eliminate the problems created by adding 12 months of prospective accountability for multiple physicians.

Measure Exclusions

In addition, we have concerns about the equity of the revised TPCC measure. We question the decision to make exclusions at the specialty level and not at the service level. While certain specialties would be excluded from this measure, the services they provide would not be excluded. Therefore, a practice comprised of excluded specialists might still be subject to the measure if it also uses a physician assistant or nurse practitioner who provides an Evaluation and Management (E/M) visit and another primary care service. This will make it hard to determine which practices are likely to be subject to the TPCC measure. It also creates a fairness issue by excluding certain specialties regarded as not providing primary care, but it then holds primary care physicians responsible for the costs of these non-primary-care services that they do not provide and cannot control.

Apples-to-Oranges Comparison

A recent study[5] published in *JCO Oncology Practice* found that oncologists scored poorly on cost measures compared with other specialties in 2018 when the Cost Performance Category made up a relatively small portion of the overall MIPS score. Now that the Cost Performance Category comprises 30 percent of the final score, oncologists may face up to a four-fold increase in magnitude of penalties. We are concerned that neither the TPCC nor the MSPB Clinician measures fully account for the variation in costs in the standard-of-care medicine by specialty and urge CMS and Acumen, LLC, to consider whether specialty-specific recalibration is needed

[5] DOI: 10.1200/OP.22.00858 *JCO Oncology Practice* 19, no. 7 (July 01, 2023) 473-483.

to prevent disparate payment penalties by specialty. Currently, we believe CMS is conducting an apples-to-oranges comparison.

Double Counting of the Same Costs

We are also concerned that TPCC and MSPB clinician double count costs when physicians are measured on episode-based cost measures. The use of total cost of care measures incorporates many of the same costs used to construct the MSPB clinician measure and the episode cost measures. A patient's total cost could be attributed to one physician, a subset of those same costs could be included in the MSPB clinician and attributed to another physician(s), and another subset of the total costs could be attributed to multiple physicians for the episode cost measures.

One concern is that the various attribution methods could provide mixed signals to physicians as to who is actually in charge of delivering efficient care. This problem is exacerbated by the fact that many of these clinicians may be unaffiliated and thus there is no real way for physicians to actually coordinate. The delay in providing physicians with lists of attributed patients also stifles real-time coordination. We believe the extent of the problem is likely to vary with the number of measures in a physician's MIPS cost score. **We urge CMS to include information about the extent of this overlap such as the distribution of the number of cost measures attributed to each TIN and TIN/NPI in its annual experience report.**

CMS does not believe costs are double counted because each measure is compared to expected costs for its own beneficiaries or episodes. However, the observed costs are still being counted multiple times within different frameworks and with different benchmarks and comparison groups. Therefore, we request that CMS elaborate on how different comparison groups and benchmarks under different measures address the issue of double counting costs and demonstrate that CMS can analyze the overlap between the revised TPCC and MSPB clinician measures and the episode measures.

Lack of Alignment with Attribution Models

CMS must address the lack of alignment of the attribution models utilized for the various administrative claims measures used for the MIPS population health quality measures and costs measures, such as Hospital-wide Readmissions (HWR), Multiple Chronic Conditions (MCC) and TPCC. Based on the proposed changes to attribution in many of these measures to hold more than one physician accountable and/or leverage different approaches (e.g., plurality of charges vs. plurality of visits), physicians and practices will have different patients assigned to them for different measures. This lack of consistency across measures will further decrease a physician's ability to drive improvements in care. The lack of a cohesive approach on attribution across one program is not sustainable and must be addressed to create a system that promotes and facilities improvements to patients in a way that is also meaningful and actionable by physicians.

CMS must address the lack of alignment of the attribution models utilized for the various administrative claims measures used for the MIPS population health quality measures and costs measures, such as HWR and TPCC. Based on the proposed changes to attribution in many of

these measures, they now hold more than one physician accountable and/or leverage different approaches (e.g., plurality of charges vs. plurality of visits).

Use of Current Procedural Terminology® (CPT®) in MSBP and TPCC Cost Measures

Current Procedural Terminology (CPT), Fourth Edition, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other qualified health care professionals. It is the most widely accepted nomenclature for the reporting of physician and other qualified health care professional procedures and services under government and private health insurance programs and is actively updated numerous times per year to keep pace with evolutions in medicine. Category I code updates become effective on January 1 of each year.
Many of the measures included in the MIPS cost measures incorporate CPT codes in their definitions. It is essential that CMS' measure specifications use the applicable CPT code set to ensure that the appropriate base and measurement data are selected for the specific timeframes.

The AMA reviewed the coding specifications currently posted to the Quality Payment Program (QPP) website for 2023 and found that the coding specifications for the MSBP and TPCC cost measures have not been updated since 2020. The Evaluation & Management (E/M) section of the CPT code set underwent its first major update in 25 years in 2021, resulting in changes to the Office & Other Outpatient visit codes. In 2023, other code ranges were updated as well, including the Inpatient & Observation codes, Nursing Facility codes, and Emergency Medicine codes to name a few. These changes are on top of the usual yearly addition/revision/deletion of codes throughout the set.

Additionally, our review of the CPT codes in the Surgical Attribution tab of the MSBP measure identified potential flaws in the coding for the surgical attribution methodology. For example, for a patient admitted to the hospital under the surgical diagnosis-related group (DRG) 040 (Peripheral/Cranial Nerve & Other Nervous System Procedures), it would be expected that a specific neurological procedure as listed in the Medicare Severity-Diagnosis Related Group (MS-DRG) specification was performed. However, in the CPT code mapping, there are many CPT procedure codes listed, such as CPT code 49561 (*Repair of trapped incisional or abdominal hernia*), that do not correspond to the principal procedures that are associated with the MS-DRG specified. In the case of MS-DRG 040, principal procedures would relate to operating room procedures such as nerve excisions, divisions, extirpations of matter, extractions, releases, and repairs. Selecting inpatient encounters based on the criteria as currently represented would not yield a sensible set of encounters suitable for quality comparisons.

The CPT coding specifications for the MSBP and TPCC measures have not been updated since 2020 and do not align with the CPT codes for the current year (2023). The AMA is concerned that the outdated measure specifications will impact the reliability and validity of the measures, as well as lead to inaccurate measure results and unintended consequences for physicians and physician groups. **The AMA strongly recommends that the MSBP and TPCC measures not be utilized to evaluate physicians on cost performance in the MIPS program at least until these issues are resolved. The AMA recommends that CMS implement processes to review**

and update all coding specifications for these measures annually to ensure that the specifications align with the most current coding conventions available.

Provide an Additional Opportunity to Comment

The American Medical Association (AMA) strongly urges the Centers for Medicare & Medicaid Services (CMS) and its contractor, Acumen, LLC, to provide an additional opportunity to comment on the 10 episode-based cost measures originally developed in Wave 2 and the two revised population-based measures – Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) Clinician when information about these measures is available. These measures were added to MIPS in the 2020 performance period and, due to the COVID-19 pandemic, the Cost Performance Category was reweighted to zero percent of the composite performance score for both 2020 and 2021. As a result, physicians did not receive feedback about their performance on these new and revised measures and there is no data about these measures in the 2020 or 2021 Quality Payment Program (QPP) Experience Reports and Public Use Files. For many physicians, they are only now seeing their preliminary performance feedback on these measures from the 2022 performance period but that information will not be final until after the review and dispute period ends long after this comment period concludes.

Without this information, there is no way to provide detailed input about whether these measures need to be reevaluated and whether these measures are valid, reliable, and appropriately capturing the costs for services during the episode of care. For example, there is no information about the top specialties who have been attributed these measures, the average and range of performance, and the number of attributed episodes. **Therefore, at a minimum, when the 2022 QPP Experience Report and Public Use Files are released, CMS and Acumen, LLC, should provide another 30-day comment window for interested medical specialty societies and other parties to provide input informed by actual data about these measures.**

3.1.28 Comment Number 28

- **Date:** 7/21/2023
- **Submitter Name, Credentials, and Organization:** Molly Peltzman, Society of Thoracic Surgeons
- **Comment Text:**

Re: MACRA Cost Measures: Call for Public Comment for Measure Reevaluation (2023)

On behalf of The Society of Thoracic Surgeons (STS), I write to provide comments on the MACRA Cost Measures: Call for Public Comment for Measure Reevaluation (2023). Founded in 1964, STS is a not-for-profit organization representing more than 7,900 surgeons, researchers, and allied health care professionals worldwide who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lungs, and esophagus, as well as other surgical procedures within the chest.

The Centers for Medicare & Medicaid Services (CMS) and Acumen, LLC are seeking public comment on the comprehensive reevaluation for the second cycle of Merit-based Incentive Payment System (MIPS) cost measures that have been in use since performance year 2020. This includes twelve measures, 10 episode-based cost measures (EBCMs) and two population-based cost measures. These measures for which CMS and Acumen are seeking comments are listed below; the first 10 are EBCMs, and the last two are population-based cost measures.

- Acute Kidney Injury Requiring New Inpatient Dialysis
- Elective Primary Hip Arthroplasty
- Femoral or Inguinal Hernia Repair
- Hemodialysis Access Creation
- Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
- Lower Gastrointestinal Hemorrhage
- Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels
- Lumpectomy, Partial Mastectomy, Simple Mastectomy
- Non-Emergent Coronary Artery Bypass Graft (CABG)
- Renal or Ureteral Stone Surgical Treatment
- Medicare Spending Per Beneficiary Clinician
- Total Per Capita Cost

The STS had several members that participated on Clinical Subcommittee (CS) workgroups in the development of the following Episode-Based Cost Measures included in Wave 2:

- Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
- Lower Gastrointestinal Hemorrhage
- Non-Emergent Coronary Artery Bypass Graft (CABG)
- Medicare Spending Per Beneficiary Clinician MACRA

As indicated in the call for public comments, these 12 measures have been in MIPS for 3 years. However, even though these measures were first adopted for the 2020 performance year, CMS was unable to calculate/score cost measures in 2020 and 2021 due to COVID-19. Thus, there is

only one true year of data related to these measures for review from 2022, which has not yet been finalized. STS is concerned that one year of data is not enough to accurately evaluate the measures. We suggest that CMS and Acumen conduct the evaluation of all Wave 2 measures after more data is available and the impact of the pandemic is no longer a significant concern. Waiting to perform the comprehensive

reevaluation of these 12 measures until additional data is obtained will ensure that there is enough information to fully evaluate the various aspects of the measures and determine what, if any, changes need to be made.

Once adequate data has been collected, STS also urges CMS and Acumen to share the comprehensive data for each measure with the professional specialty societies. This will allow the specialty societies to evaluate how the relevant measures are being applied to determine whether changes are necessary. Without access to the data, it is difficult to evaluate the accuracy and impact of the measures on our members.

Thank you for the opportunity to provide these comments. Please contact Molly Peltzman, Associate Director of Health Policy, at *[redacted]* or Derek Brandt, Vice President of Government Relations at *[redacted]* should you need additional information or clarification.

3.1.29 Comment Number 29

- **Date:** 7/21/2023
- **Submitter Name, Credentials, and Organization:** Lakitia Mayo, American Society for Gastrointestinal Endoscopy, American College of Gastroenterology, American Gastroenterological Association
- **Comment Text:**

July 21, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Submitted via https://acumen.qualtrics.com/jfe/form/SV_1Oc6oL3JqK5zSoC

Re: Comprehensive Reevaluation of Lower Gastrointestinal Hemorrhage Episode-based Cost Measure and Population-based Cost Measures

Dear Administrator Brooks-LaSure:

On behalf of the American College of Gastroenterology (ACG), American Gastroenterological Association (AGA), and American Society for Gastrointestinal Endoscopy (ASGE), we thank you for the opportunity to comment as the Center for Medicare & Medicaid Services (CMS) and Acumen, LLC, gather input about episode-based cost measures that have been in use in the Merit-based Incentive Payment System (MIPS) since performance year 2020 and are being considered for comprehensive reevaluation. Our comments focus on the "Lower Gastrointestinal Hemorrhage" episode-based cost measure as well as the population-based cost measures, Medicare Spending Per Beneficiary Clinician and Total Per Capita Cost.

LOWER GASTROINTESTINAL HEMORRHAGE

Consideration of Revision to the Patient Cohort

Physician representatives from each of our societies actively participated in the "Gastrointestinal Disease Management – Medical and Surgical Clinical Subcommittee." We believe members of this subcommittee were part of a successful and deliberative process when developing the "Lower Gastrointestinal Hemorrhage" episode-based cost measure. Careful consideration was given to the patient cohort for the measure, as defined by trigger codes and exclusions, in the context of current clinical practice. There have been no changes in clinical practice that would necessitate updating the measure.

Consideration of Inclusion of Upper Gastrointestinal Hemorrhage

The "Lower Gastrointestinal Hemorrhage" episode-based cost measure accounts for diagnostic colonoscopies performed for the indication of colonoscopy for lower gastrointestinal hemorrhage. Consideration of inclusion of upper gastrointestinal hemorrhage in this measure was discussed thoroughly during development of the episode. It was determined that this episode should incorporate lower gastrointestinal hemorrhage only.

Our societies would not agree with the suggestion drawn from the results in Table 5 "that including upper gastrointestinal bleeding in the measure could more than double the current sample size, and that episodes that include upper gastrointestinal bleeding have relatively similar observed cost to those limited to lower gastrointestinal bleeding." The fallacy here is with assuming that lower gastrointestinal bleeding cases and upper gastrointestinal bleeding cases are similar. The patient population, etiology, and management approaches to these conditions vary widely as do the resources to care for such patients based on the setting of presentation. For example, the cost of caring for a patient with cirrhosis admitted with decompensation and variceal hemorrhage (including antibiotics, proton pump inhibitor and octreotide infusions, evaluation and management of ascites or associated peritonitis, encephalopathy) requiring ICU care and possibly leading to transjugular intrahepatic portosystemic shunt, or a duodenal ulcer amenable to endoscopic therapy is different from the cost associated with caring for a patient with diverticular bleeding. We urge that clinicians be provided with the right data for the right reason.

We believe grouping upper endoscopy with diagnostic colonoscopy would be fraught with issues, make management of the data more complex and prone to irregularity, and would risk undervaluing both diagnostic colonoscopy and upper endoscopy. These procedures and the conditions they treat are very different and by combining the costs, any potential use of the data for quality improvement would be limited nor do we believe that combining them is appropriate for accountability purposes. Further, the heterogeneity of the sites of service, ancillaries, conditions, secondary procedures, and other factors would make analysis and evaluation challenging, and it would prove difficult if not impossible to provide meaningful information to the clinician. Based on these concerns, **our societies strongly oppose expansion of the scope of the "Lower Gastrointestinal Hemorrhage" episode-based cost measure to include upper gastrointestinal hemorrhage.**

Meaningful Measurement of and Feedback to Clinicians

The "Lower Gastrointestinal Hemorrhage" episode-based cost measure was introduced into MIPS in the 2020 performance year, following introduction of the "Screening/Surveillance Colonoscopy" episode-based cost measure in the 2019 performance year. It is well-understood that the care required and associated costs for the "Lower Gastrointestinal Hemorrhage" measure differs significantly from the "Screening/Surveillance Colonoscopy" episode-based cost measure. A colonoscopy done for episodes of colon cancer screening and surveillance must be distinguished from those done for other clinical diagnostic or interventional situations such as upper gastrointestinal hemorrhage, lower gastrointestinal hemorrhage, stenting for bowel obstruction, diagnosis of inflammatory bowel disease or ischemic colitis due to the large differences in incurred resource utilization for these procedures and complex care management by numerous providers. Moving forward, our societies believe these two distinct measures will be helpful to gastroenterologists in managing resource utilization, including the decision and opportunity to use non-hospital-based sites of service when available. It is imperative clinicians are provided with meaningful, transparent, and actionable information that justifies assignment as a low- or high-cost provider and supports beneficial changes in practice behaviors.

Further, the complexity of episode groups should continue to be minimized as clinicians gain experience in understanding the Merit-based Incentive Payment System (MIPS) and use of the feedback received, recognizing the public health emergency greatly impacted participation in MIPS and by extension measure results, benchmarks established, and receipt of feedback reports. It is vital to ensure the accuracy of these episodes of care and meaningfulness to clinicians. In fact, CMS only just released the 2022 cost benchmarks, which is the first time that clinicians can see how some of these measures perform across all MIPS participants.

The goal should be the development and maintenance of each episode-based cost measure and the delivery of feedback reports that are conducted in such a way that clinicians in practices of all sizes can easily interpret the reports so actionable steps can be identified to improve patient care and cost efficiencies. Significant revision to "Lower Gastrointestinal Hemorrhage" episode-based cost measure should not be considered given that there has been limited experience with the current measure by CMS and clinicians. To that end, **we strongly recommend CMS reconvene the clinical experts who served on the subcommittee to fully vet public input before making any revisions to the measure.**

POPULATION-BASED COST MEASURES

Our societies share the detailed concerns expressed by the American Medical Association (AMA) relative to the Medicare Spending Per Beneficiary (MSPB) Clinician and Total Per Capita Cost (TPCC) population-based cost measures. We would highlight the following points from AMA's letter.

In summary, our societies recommend the following:

- Do not expand the scope of the "Lower Gastrointestinal Hemorrhage" episode-based cost measure to include upper gastrointestinal hemorrhage
- Reconvene the clinical experts who served on the subcommittee so they can fully vet public input before making any revisions to the "Lower Gastrointestinal Hemorrhage" episode-based cost measure.
- Give careful consideration to concerns outlined by the AMA in its [date] letter relative to the MSPB and TPCC population-based measures.

Our societies appreciate the opportunity to provide feedback. If you have any questions about our comments or if we may provide any additional information, please contact Brad Conway, ACG, at *[redacted]* or *[redacted]*, Leslie Narramore, AGA, at *[redacted]* or *[redacted]*, or Lakitia Mayo, ASGE, at *[redacted]* or *[redacted]*.

Respectfully,

Daniel Pambianco, MD, FACG
President, American College of Gastroenterology

Barbara Jung, MD, AGAF
President, American Gastroenterological Association

Jennifer Christie, MD, FASGE
President, American Society for Gastrointestinal Endoscopy

3.1.30 Comment Number 30

- **Date:** 7/28/2023
- **Submitter Name, Credentials, and Organization:** Kailee Boedeker, Society of Interventional Radiology
- **Comment Text:**

July 28, 2023

Comment Letter: MACRA Cost Measures: Measure Reevaluation

The Society of Interventional Radiology (SIR) appreciates the opportunity to submit feedback on the second cycle of comprehensive reevaluation for episode-based cost measures.
SIR is a professional medical association that represents approximately 8,000 members, including most U.S. physicians practicing in the specialty of vascular and interventional radiology. The society seeks to improve lives through image guided therapy. We understand the importance of cost measures within healthcare, especially those that are relevant to interventional radiology practice. We appreciate the opportunity to be involved and represented by these measures and look forward to our continual involvement with The Centers for Medicare & Medicaid Services (CMS) and the measures process.

Hemodialysis access creation, lower gastrointestinal (GI) hemorrhage, and renal or ureteral stone surgical treatment are all a part of the spectrum of conditions and procedures covered by interventional radiologists that impact a significant and increasing number of patients each year. Interventional radiologists provide comprehensive, longitudinal care and are a critical part of the multi-disciplinary team that treats patients that fall within each of these clinical/treatment focus areas.

Upon review of the current cost measure, hemodialysis access creation, our physicians found the listings of triggers, exclusions, or risk adjustments to be generally appropriate and accurate from their clinical perspectives. Regarding risk adjustments, they do propose the addition of the number of previous and failed AVF and/or AVGs, as this correlates with the complexity of the current intervention. They also propose the addition of a risk adjustment related to receipt of dialysis at the time of creation via central venous catheters, as this correlates with the patient's health at the time of the procedure. The reviewers also noted that interventional radiologists will only potentially be involved with the creation of AVF, which is created percutaneous, and a vascular surgeon is required to create an AVG.

Our physicians reviewed the lower GI hemorrhage measure scope and are supportive of the suggestion to include non-variceal upper GI hemorrhage in the measure and to establish sub-groups between upper and lower hemorrhage. They noted that etiologies, location, and therapies are quite different for variceal vs. non-variceal bleeds. The addition of non-variceal upper GI hemorrhage would expand the patient cohort significantly, but that sub-group categorization between upper and lower is critical, as the two conditions will likely see significant differences in patient demographics, etiology, recurrence rates, and complications. Additionally, the two groups will likely show differences between treatment approaches in terms of the rates of either GI (endoscopic) vs. endovascular treatment as first-line, or differences in rates of using end-vascular therapy as salvage if endoscopy is unsuccessful. They are supportive of more clearly categorizing patients at higher risk for re-bleeding, reducing the incidence of recurrent bleeding, and improving the use of early intervention strategies to mitigate the risk for catastrophic bleeding and other complications. Including both upper and lower GI would allow for additional risk prevention for patients with upper GI hemorrhages while preserving the integrity of the lower GI hemorrhage measure through sub-grouping.

Lastly, after reviewing the renal or ureteral stone surgical treatment measure, our physicians found the listings of triggers, exclusions, and risk adjustments to be generally appropriate and accurate from their clinical perspectives. They suggest the addition of course of disease greater

than 12 months, prior nephrolithotomy on the same side, the degree of hydronephrosis, stone size, and a number of stones with regard to risk adjustment. These factors all have a direct impact on procedure complexity and if incorporated into the list of risk adjustments, would add value to the measure. The review also noted that the subgroups of PCNL, ESWL, and URS accurately reflect mutually exclusive types of episodes.

Given the importance of interventional radiologists' involvement in the care of patients in need of hemodialysis access creation, with lower GI hemorrhage or undergoing renal or ureteral stone surgical treatments we strongly encourage CMS to include interventional radiologists during all stages of the measurement development process going forward.

Thank you again for the opportunity to comment. We encourage you to reach out if you have any questions or if we can provide any additional resources. Feel free to contact Kailee Boedeker (*[redacted]*) or Liza D'Onofrio (*[redacted]*).

Sincerely,

Thomas J. Ward, MD
Co-chair, SIR Performance and Outcomes Measures Committee

Andrew Taylor, MD
Co-chair, SIR Performance and Outcomes Measures Committee

3.1.31 Comment Number 31

- **Date:** 7/31/2023
- **Submitter Name, Credentials, and Organization:** Alice Bell, American Physical Therapy Association
- **Comment Text:**

[4.1. Please provide your feedback for the Elective Primary Hip Arthroplasty measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

On the Service Assignment List the code for Physical Therapy Evaluation is listed as 97001. The Evaluation codes were changed to 97161, 97162, and 97163 in 2016 and CPT code 97001 is no longer active. APTA wants to ensure that this is corrected in the data base for this measure.

APTA additionally notes that CPT codes 97110, 97140, and 97530 are specifically listed as sometimes assigned based on diagnosis for physical therapy on one section of the excel spreadsheet but there are other notations indicating that Diagnostic Physical therapy and physical therapy exercises, manipulation, and other procedures, other physical therapy and rehab and HH PT are sometimes assigned based on diagnosis. APTA requests clarification as to whether only certain CPT codes are assigned based on diagnosis or whether all PT services are assigned based

on diagnosis for this cost measure. If codes are restricted APTA recommends adding CPT codes 97164, 97116 and 97150 for service assignment.

[7.1. Please provide your feedback for the Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

Diagnostic physical therapy is sometimes assigned based on diagnosis. No CPT codes are listed.

APTA recommends adding CPT codes 97161, 97162, 97163.

97110, 97112, 97116, 97150 are assigned based on diagnosis.

APTA recommends adding 97164, 97124, 97140, and 97535 to the CPT code list.

[9.1. Please provide your feedback for the Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

Diagnostic physical therapy assigned based on diagnosis (no specific CPT code)

Physical Therapy Exercises, Manipulation and Other Codes and Physical Therapy Revenue Code 042 Home Health depending on diagnosis â€“ no CPT codes listed.

APTA seeks to clarify that this means that all codes billed by physical therapists would be included in the cost measure based on diagnosis.

[10.1. Please provide your feedback for the Lumpectomy, Partial Mastectomy, Simple Mastectomy measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

APTA recommends inclusion of diagnostic physical therapy (97161, 97162, 97163) and all codes billed by physical therapists for inclusion in this measure. Physical therapists play an important role in the recovery of functional capabilities for many patients with cancer.

[11.1. Please provide your feedback for the Non-Emergent Coronary Artery Bypass Graft (CABG) measure in the text box below. As a reminder, you may also upload a comment letter at the end of the survey.]

Physical Therapy Exercises, Manipulation, and other procedures is always assigned regardless of diagnosis.

Other physical therapy and rehabilitation is always assigned regardless of diagnosis

Home Health Revenue center 042 sometimes assign based on diagnosis.

APTA seeks to clarify that this means that all codes billed by physical therapists would be included in the cost measure based on diagnosis.

[14.1. The measure currently uses exclusions based on both services and HCFA Specialty to ensure that the measure only captures clinicians who provide primary care or care across multiple conditions. The advantage of service category exclusions is that it focuses on the care actually provided by clinicians, since HCFA Specialty lacks granularity for subspecialties who may provide different types of care. The disadvantage is that these definitions are more complex than HCFA Specialty exclusions. Should the measure use only one type of exclusion rule to simplify the specifications? If so, which exclusion method should be used and why?]

APTA recommends that exclusions be based on services only and that HCFA Specialty not be a blanket exclusion rather the exclusion should be based on the provider type's ability to bill independently and provide services without a referral.

[14.2. If the measure continues to use both service category and HCFA Specialty exclusions, what changes (if any) should be made to ensure that the measure is appropriately capturing clinicians who provide primary care type services?]

APTA believes providers who bill independently and are able to be accessed by patients/clients directly should not be excluded. This would include physical therapists for whom direct access laws exist in all 50 states, the district of Columbia, and the US territories.

[14.3. The trigger rule methodology uses outpatient evaluation and management (E&M) codes to identify a clinician-patient relationship. There are many types of clinicians who do not bill E&M codes, such as physical therapists, occupational therapists, speech language pathologists, clinical psychologists, licensed clinical social workers, etc. This means that these specialties are effectively excluded from the measure. Should the trigger methodology be expanded to include clinicians who do not bill E&M codes? If so, what services do these specialties provide that should be added to the trigger methodology to identify a primary care or similar relationship?]

APTA believes CPT codes 97161, 97162, and 97163 should be added as candidate event codes and that all codes billed by physical therapists be included in the measure.

97161, 97162, and 97163 are included as trigger codes in the low back pain measure as physical therapists may be the first point of contact and the primary provider for patients with MSK conditions. This is true for other conditions as well, particularly chronic and/or progressive diseases/conditions.